RESOURCE AND PATIENT MANAGEMENT SYSTEM

PCC+ Encounter Form & Health Summary Package
(VEN)

User's Guide

Version 1.2
June 2002

Information Technology Support Center
Division of Information Resources
Albuquerque, New Mexico

PREFACE

This manual contains the users guide for the IHS RPMS New encounter form and health summary Package (PCC+) version 1.2. Installation and technical manuals are also provided with this installation package.

TABLE OF CONTENTS

1.0 Introduction

The new encounter form and health summary Package (PCC+) enables IHS health professionals to design and generate highly customized encounter forms and health summaries on a laser printer. The new encounter form combines features of the traditional Patient Care Component (PCC) encounter form, super bill and health summary, and it replaces the first two of these documents. Customized elements of the form come from the PCC database (demographic information, eligibility data, problems, purposes of visit, allergies, health maintenance reminders and medications), the site preference files (orderables and associated CPT codes) and the user preference file (diagnoses and associated ICD codes). Because the new encounter form and health summary Package extends the traditional functions of PCC, we call it PCC+. For the sake of brevity, the acronym PCC+ will be used throughout this document.

The user manual for the PCC+ program explains the process of creating and generating customized forms. This manual is divided into four main sections:

1. **How to build and edit encounter forms**: The primary form-building tool is Microsoft Word. You will learn how to create elements of the form and how to link certain elements to the PCC database.

2. **How to customize the encounter forms with user and site preferences**: the primary preference-building tool is Microsoft Excel. This tool is supplemented with several FileMan editing utilities provided in this package.

3. **How to print encounter forms**: Forms are generated during the patient check-in process. This section describes the various methods and options for generating forms and monitoring the process.

4. **How to use the encounter forms**: This section describes the best ways to take advantage of this new technology with emphasis on using the form to improve clinical care and third party reimbursement.

Sample forms are shown in Appendix A. These samples provide ideas for IHS sites on where to start and what to include in the form. Of course, a site's local processes and preferences will dictate the final form design. Consider contacting sites that have already created forms to obtain additional samples to add to Appendix A of this manual.

The user manual is a comprehensive guide to designing encounter forms, identifying user preferences, and using PCC+. . Although there is a lot of material to cover, most users become proficient with a few days of practice.

2.0 Building an Encounter Form

Encounter form templates are constructed using Microsoft Word®. We suggest using the Word application that has been loaded and pre-configured on your print server. If development is not being done on the print server, any Windows PC that runs Word 98 or Word 2000 may be used.

> **NOTE**: The print server is a computer whose primary purpose is to print all PCC+ forms at your facility. It also contains specially configured versions of Microsoft Word 2000 and Excel 2000. Your site manager can give you access to this PC for the purpose of developing and editing encounter forms.

The development process consists of the following 7 steps:

1. Extend Word's toolbar and make other configuration changes
2. Create a new document
3. Use the undo, redo, and repeat functions
4. Make text boxes
5. Create tables
6. Connect the form to the database via mail merge
7. Copy components from pre-existing documents

2.1 Configure Word

This section explains how to extend Word's toolbars and make other configuration changes necessary to support the process of building an encounter form. If you are doing your form development on a pre-configured PCC+ Print Server, the extended toolbar and other changes should already be present, and you are free to skip this section.

2.1.1 Extend the Toolbar

The key to productive PCC+ template use is having the right tools at your fingertips. Extending the standard Word toolbar to better meet the needs of the template facilitates this process. Customize your toolbars before creating a document. It saves time and helps you to flow smoothly through commands.

1. Open the Word application.

2. Activate the Drawing toolbar.

   - Click the View option on the main menu bar. A drop down menu appears.

   - Click the Toolbars option.

- Verify that the drawing toolbar is active. (If there is a checkmark next to *Drawing*, it is activate.) If the drawing toolbar is not active, activate it by clicking the Drawing option in the drop down menu. The drawing toolbar will appear on your screen.

3. Click the Tools option on the main menu bar. A drop down menu appears (Figure 2-1). Click the Customize option. The Customize window appears (Figure 2-2).

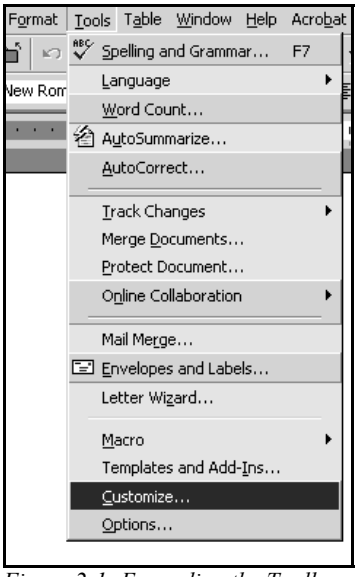


Figure 2-1: Expanding the Toolbar, Step 3

4. Click the Commands tab (Figure 2-2).

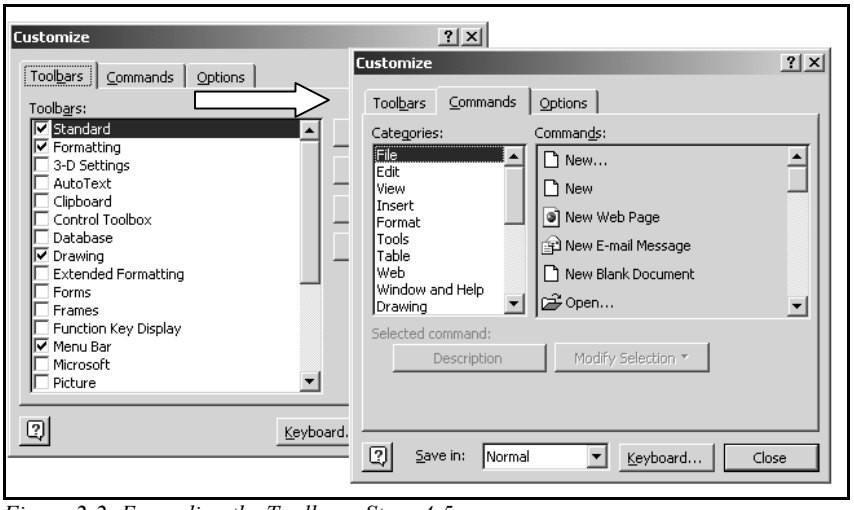


Figure 2-2: Expanding the Toolbars, Steps 4-5

5. Select a category from the categories list in the left column to view a set of available commands in the right column (Figure 2-2).

6. Move a command to the toolbar.

- Click on a command to highlight it.
- Hold down the left mouse button to capture the command icon and drag it to the Drawing toolbar (Figure 2-3).
- Release the left mouse button and the icon appears on the toolbar.

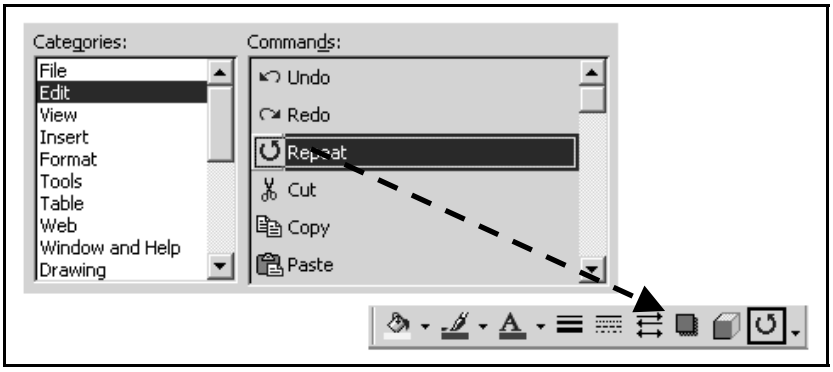


Figure 2-3: Extending the Toolbars, Steps 5-6

Each category houses different commands, which are represented by different icons:

Suggested Commands to Add for Encounter Form Creation		
Category	**Command**	**Icon**
Drawing	Group	
	Ungroup	
	Regroup	
	Bring to front	
	Send to back	
	Free rotate	
	Crop	
Tables	Delete rows	
	Insert rows	
	Insert Columns	
Format	Grow font 1 pt	
	Shrink font 1 pt	
	Single spacing	
	1.5 spacing	
	Double spacing	
File	Page setup	
Edit	Repeat	
	Redo	
View	Fit to window	
	Show/hide formatting	
	Zoom 100%	

The Standard toolbar should look like Figure 2-4and contain the following tools:

File	New
	Open
	Save
	Print
	Page Setup
	Print Preview
Format	Fit to Screen
	Fit Page in Window
	Zoom
	Show/Hide Formatting
Tools	Spelling Check
Edit	Cut
	Copy
	Paste
	Paste Format
	Undo
	Redo
	Repeat
Table	Insert Table
	Table and Borders
	Outside Borders
	Insert Row
	Remove Row
	Insert Column
	Remove Column
Format	Columns
Drawing	Drawing Toolbar
View	Magnifying
Window and Help	Microsoft Help

Figure 2-4: Standard Toolbar

The Formatting toolbar should look like Figure 2-5 and contain the following tools:

Format	Style Selector
	Font Style Selector
	Font Size Selector
	Bold
	Italic
	Underline
	Word Underline
	Grow Font 1 Point

	Shrink Font 1 Point
	Align Left
	Align Center
	Align Right
	Align Justified
	Number
	Bullet
	Decrease Indent
	Increase Indent

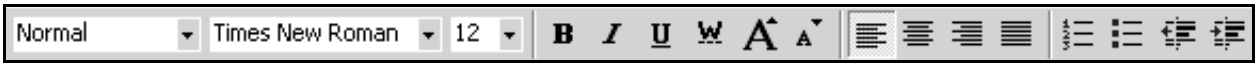


Figure 2-5: Formatting Toolbar

The Drawing toolbar should look like Figure 2-6 and contain the following tools:

Drawing	Group
	Ungroup
	Regroup
	Bring to Front
	Send to Back
	Free Rotate
	Crop
	Remove Row
	Insert Row
Format	Grow Font 1 Point
	Shrink Font 1 Point
	Single Space
	1.5 Space
	Double Space
File	Page Setup
Edit	Repeat
	Redo
View	Fit to Screen
Format	Line Style
View	Show/Hide Formatting
	Zoom 100%

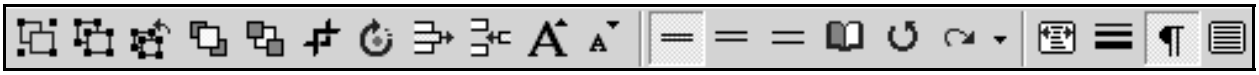


Figure 2-6: Drawing Toolbar

2.1.2 Additional Setup Changes

There are three additional preparatory steps necessary to configure Word to create encounter forms.

1. Select an HP series printer.
    - Click Start > Settings > Printers.
    - Select an HP series printer as the default printer while designing any PCC+ form. If there is no HP printer listed, add one.
2. Deactivate the drawing grid.
    - Click the Draw option on the drawing toolbar. A drop down menu appears.
    - Click the Grid option.
    - Deactivate the *Snap to Grid* function, if necessary. (If the Snap to Grid function is activated, there is a checkmark next to it. Click the Snap to Grid option to remove the checkmark and deactivate this feature.)
3. Change page margins.
    - Click the File option on the menu bar. A drop down menu appears.
    - Click the Page Setup option. The Page Setup window opens.
    - Click the Margins tab. Type .4 in the Top field. Type .5 in the Bottom field. Type .4 in the Left field. Type .5 in the Right field (Figure 2-7).
    - Click the OK button on the Page Setup window to save your changes. This configures the template margins to correspond to the HP series printers.

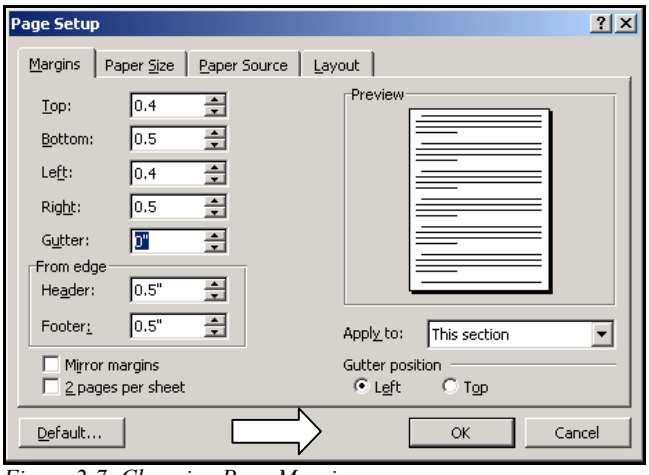


Figure 2-7: Changing Page Margins

2.2 Create a Document

The first document, a page that looks like a sheet of notebook paper, provides the foundation for all encounter forms.

1. Open a new page.
    - Click the File option on the menu bar. A drop down menu appears.
    - Click the New option. A blank document appears.
2. Format the font (Figure 2-8).
    - Click the Format option on the menu bar. A drop down menu appears.
    - Click the Font option. The Font window appears.
    - Select the Arial Narrow option in the Font: field.
    - Select the 16 option in the Size: field.
    - Select the Gray – 25% option from the Color drop down list.
    - Click the OK button at the bottom of the Font window to save your changes.

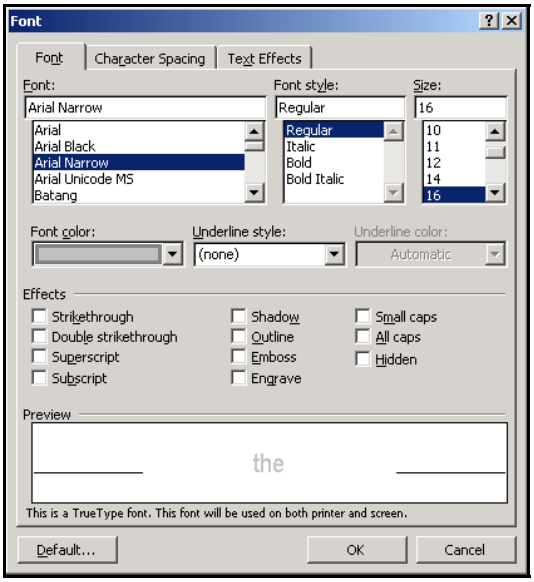


Figure 2-8: Formatting the Font

3. Line the page (Figure 2-9).
    - Click the ¶ icon (show/hide formatting) on the toolbar. Characters or symbols appear for all Word keystrokes (e.g., paragraph marks, tabs, etc.).

- Press the tab key until you have arrows across one entire line.
- Highlight the line by positioning your cursor on the first arrow and while holding down the left mouse button, drag the cursor to the last arrow and release the button.
- Click the  icon (underline function) to create a line.
- Repeat this process for the entire page, creating a lined page. (Use the copy and paste function if desired.)

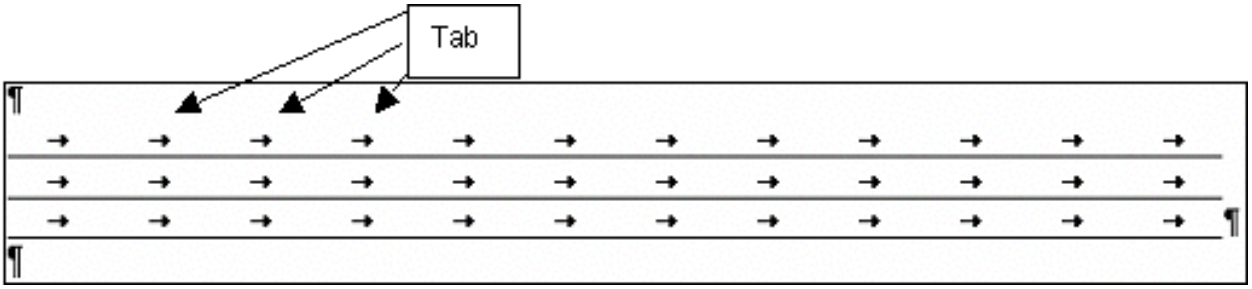


Figure 2-9: Creating a Lined Page

4. Copy page one to page two.
   - Highlight the page by pressing the Ctrl + A keys.
   - Click the  icon (copy) on the standard toolbar.
   - Place the cursor at the bottom of the first page and press the Ctrl + Enter keys. This forces the creation of a new page.
   - Place the cursor at the top of the new page and click the  icon (paste). An exact copy of page one appears on page two.

2.3 Redo and Repeat

Before proceeding, it is useful to learn about the icons in the standard toolbar.

Undo Icon: Allows a user to undo a mistake made and return to an earlier state. Multiple levels of undoing are allowed. Just keep pressing the undo icon to repeal a series of changes made to the document.

Redo Icon: Allows a user to "undo an undo." Multiple levels of redo are allowed.

Repeat Icon: Allows you to repeat a *single* formatting change multiple times. For example you can change the line thickness, shading, and font size in multiple sections of the document. Just highlight the area you want to change and press the repeat icon.

Figure 2-10: Undo, Redo, and Repeat Tools

2.4 Text Boxes

The next step is to superimpose additional design elements (also called components or objects) on top of the lines. The best approach is to put these elements in a container called a text box for easy positioning.

2.4.1 Creating a Text Box

1. Click the  icon (insert text box). Your cursor changes to a + when it is moved onto the paper.

2. Position the cursor (+) at the upper left corner of the page.

3. Click and hold the left mouse button and move the mouse toward the lower right corner of the page. The text box appears. Make your box smaller or larger by dragging the corner with the mouse.

4. When the box is the desired size, release the mouse button. The text box shows a border with slashes and resizing marks.

2.4.2 Manipulating a Text Box

All objects should be in text boxes for easy manipulation and positioning. This section explains the text box mechanics required to manipulate and work with text boxes.

2.4.2.1 Borders

When a text box is highlighted, a border surrounds it. There are two types of borders: slashed and dotted. A slashed border indicates that the box only allows text editing. A dotted border indicates that the box will allow the entire text box to be manipulated (i.e. copied, pasted, deleted). Click a slashed border to transform it to a dotted border. (Figure 2-11)

For example, if the border is changed to a dotted border, the text box can be moved, copied, or deleted. You can also globally change the font of all the text within the box. If the border is changed to a slashed border, individual pieces of text within the box can be added, edited, or deleted.

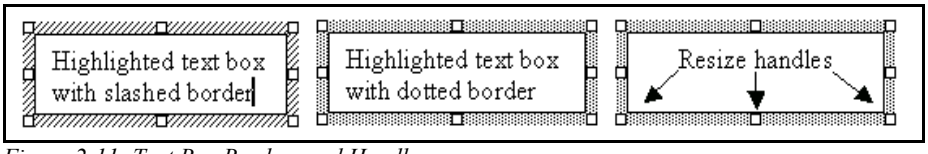


Figure 2-11: Text Box Borders and Handles

To activate the dot border: If there is no border on the text box, move the cursor over the edge of the textbox until the cursor changes to four pointers. Then left click and the dots appear.

To activate a slashed border, place the cursor over the middle of the object and left click and slashes appear.

To change the border from slashes to dots, move the cursor over the border until it changes to four pointers. Then left click and the slashes changes to dots. Review the instructions given previously for adjusting the formatting of all text within the box.

2.4.2.2 Resizing and Moving

The resizing marks allow you to make the text box smaller or larger (Figure 2-11). Marks in the corners allow manipulation in two dimensions—height and width—while marks on the top, sides, and bottoms only manipulate height or width.

Place the mouse indicator on a resize marker and left click. Continue to depress the button and move the cursor to change the size of the box. The entire text box may be moved by first highlighting it (clicking on the box until the dot border appears).

Place the mouse position indicator on the border. A symbol of four pointers appears. Press and hold the left mouse button and move the mouse. The text box also moves. When the box is in the desired location, release the mouse button. You can also nudge a text box, fine tuning the text box placement, using the arrow keys. While the box is highlighted with the dot border, press the arrow keys, the box is nudged slightly in the direction of the arrow key.

If the show/hide formatting feature (¶) is active, an anchor appears in the margin of the document when the text box is highlighted. This anchor indicates the line of the document that the text box is attached to. If the line is moved, the anchor and text box move with it. If the text box is moved, the anchor changes positions. To move the anchor, place the mouse position indicator on the anchor and drag it. The anchor position is important because it locks the text box in place. If a line that a text box is anchored to is moved or deleted, the text box also moves or is deleted.

2.4.2.3 Changing the Contents of the Text Box

To make global formatting changes to the contents of the box, activate the dot border. To add text to the box, click anywhere inside a text box to highlight it (make a slashed border appear). While the box has the slashed border, position the cursor inside the box and start typing.

Delete the contents of a text box by highlighting the box with the slashed border. Highlight the text you wish to delete by placing the mouse cursor at the beginning of the section. Press and hold the left mouse button and move the indicator over the items to be

deleted. Release the left mouse button at the end of the selection and press the Delete or Backspace key on your keyboard.

2.4.2.4 Wrapping Text Around the Text Box

In order for the text boxes to position themselves correctly on the form, the text wrapping function needs to be adjusted. While the text box is highlighted with either the dotted or slashed border, the wrapping parameter may be changed.

1. Highlight the text box that you wish to change the wrapping parameter for.
2. Click the Format option from the menu bar. A drop down box appears.
3. Click the Format Text Box option. The Format Text Box window appears.
4. Click the Layout tab in the Format Text Box window.
5. Click the Advanced button at the bottom of the Format Text Box window. The Advanced Layout window opens (Figure 2-12).
6. Click the Text Wrapping tab in the Advance Layout window.
7. Click the In Front of Text option (Figure 2-12).

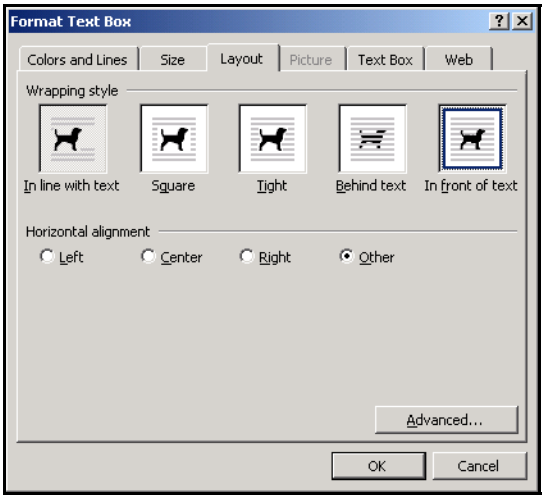


Figure 2-12: Setting Text Wrapping Properties

2.4.2.5 Setting Text Box Borders

Changing the Line Color

A lined border can be added to or removed from a text box with the  icon (line function) on the drawing toolbar.

1. Click on the text box and activate a dotted border.

2. Click the line icon arrow (the down arrow to the right of the line icon). A drop down window with line selections appears (Figure 2-13).

3. Click the No Line option and the border disappears (Figure 2-13).

4. Repeat this process, this time setting the line color to black. The line reappears (Figure 2-13).

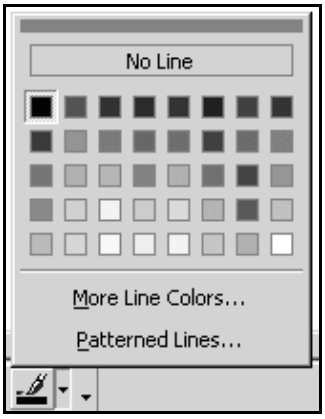


Figure 2-13: Selecting a Text Box Line Color

Changing the Border Thickness

To change the thickness of the border line:

1. Click on the text box and activate a dotted border.

2. Click the  icon (line thickness). A drop down window with line selections appears (Figure 2-14).

3. Select the line thickness desired from the options that appear (Figure 2-14).

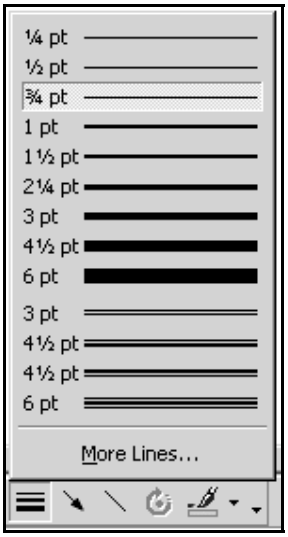


Figure 2-14: Selecting a Text Box Border Width

Setting Text Box Fill Colors

You can set the fill color of the text box with the fill color icon. Since the encounter form is not printed in color, the color choices are limited to black, white, shades of gray, and no fill color (i.e., a transparent box).

1. Click the text box and activate a dotted border.
2. Click the fill color icon arrow (the down arrow to the right of the fill icon). A drop down window with fill color selections appears (Figure 2-15).
3. Click the No Fill option and the text box becomes transparent (Figure 2-15).
4. Repeat this process, this time setting the fill color to white. The text box becomes opaque.

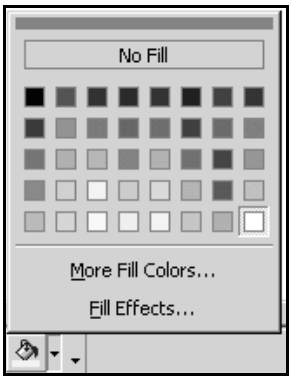


Figure 2-15: Text Box Fill Color Selection

Grouping Text Boxes

To join two text boxes into a single object:

1. Click the first text box and activate the dotted or slashed border.
2. Press the Shift key and, while holding down the Shift key, left click the second text box. Both boxes should be highlighted.
3. Click the  icon (group) to join the text boxes into one object.
4. Reverse this by highlighting the joined object and clicking the  icon (ungroup).

Layering Text Boxes

1. Click the first text box to be layered over another text box and click the  icon (bring-to-front).
2. Click the second text box and click the  (send-to-back).

3. Drag the text boxes so they partially overlay one another.

4. Reverse the process by clicking the second text box and clicking the bring-to-front icon.

2.5 Tables

Always create tables within a text box so the table can be easily moved around the page.

1. Create a text box. Leave the text box with a slashed border.

2. Click the Table option on the menu bar. The table drop down menu will appear (Figure 2-16).

3. Click the Insert Table option on the Table menu. The Insert Table window opens.

4. Type the number of columns desired in the Number of Columns field (Figure 2-16).

5. Type the number of rows desired in the Number of Rows field.

6. Type the column width desired in the Column Width field.

7. Click the OK button to create the table.

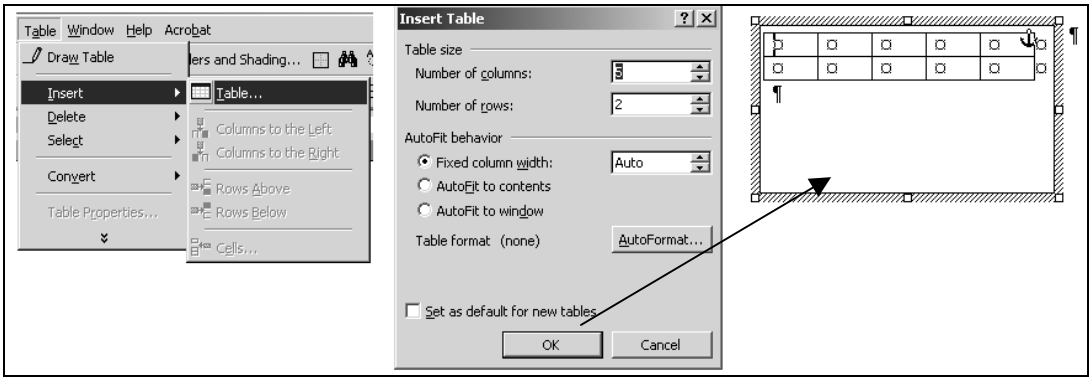


Figure 2-16: Creating a Table in a Text Box

8. Set the text box border selection to the No Line option. When working with the encounter form, the text box borders are not usually needed.

2.5.1 Highlighting a Table

Edit the table within the text box. Begin by highlighting the table. There are several methods you can use to highlight the table.

To highlight the entire table

1. Click the Table option on the menu bar.

2. Click the Select Table option on the Table menu.

Highlight one cell

1. Move the cursor over left the border of the cell until an arrow appears.
2. Click the left mouse button once the arrow appears.

Highlight several cells

1. Mover the cursor over left the border of the first cell until an arrow appears.
2. Click the left mouse button on the first cell.
3. Drag the mouse indicator to the last cell to be highlighted and release the mouse button.

Highlight cells using the arrow keys

1. Place the cursor in the first cell you wish to highlight.
2. Press the Shift key and an arrow key. The cells highlights one at a time each time you press the arrow key.

2.5.2 Changing Column Width and Row Height

1. Click the Table option on the menu bar.
2. Click the Table Properties option (or cell height and width in Windows 98). The Table Properties window will open.
3. Click the Row tab to change the row height (Figure 2-17).
4. Click the Column tab to change the column width (Figure 2-17).
5. Click the OK button to accept your changes and return to the highlighted table.

The column width can also be changed by placing the mouse cursor on the line to be adjusted. A ←‖→ symbol appears. This symbol captures the line and allows the line to be moved from side to side for vertical lines and up and down for horizontal lines.

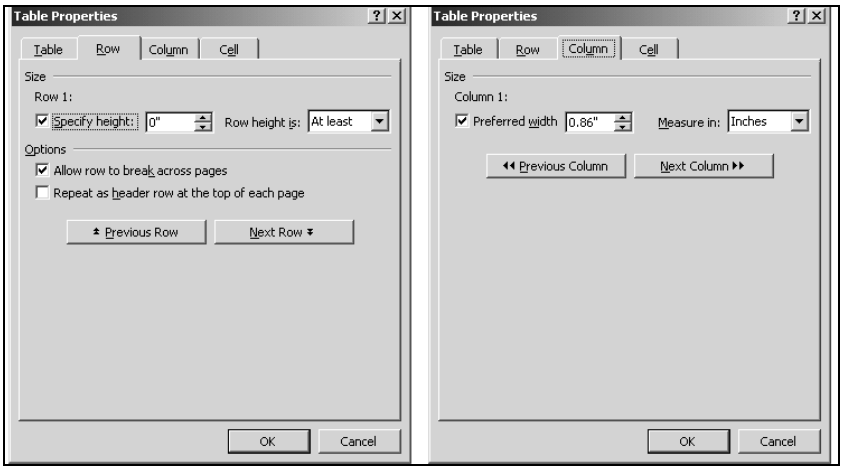


Figure 2-17: Table Row and Column Settings

2.5.3 Splitting and Merging Cells

Cells within a table may be split or merged. A merged cell appears as one cell that is larger then the surrounding cells. Merged cells are commonly used for the top row or tile of a title. Split cells appear as two or more smaller cells (either vertical or horizontal) in relationship to the surrounding cells.

To Merge Cells

1. Highlight the cells to be merged.

2. Click the Table option on the menu bar.

3. Click the Merge Cells option on the Table menu. The dividing lines disappear between the cells. Text can be added across the entire cell or centered within the cell. To center text in a merged cell, highlight the text and click the icon (align center).

4. Typically, the title row (the table's top row) is a merged cell. If you resize the table after merging a row, you will have to resize that row separately. Another approach is to delete the merged row and then insert a new row after you have resized the table.

To Split Cells

1. Highlight the cells to be split.

2. Click the Table option on the menu bar.

3. Click the Split Cells option on the Table menu. The Split Cell window will open.

4. Type the number of columns and rows to split the cell in to. Click the OK button at the bottom of the Split Cell window.

2.5.4 Setting Table Borders

Individual lines surrounding a table or the entire border surrounding a table may be removed (or added) using the border icon on the standard toolbar (Figure 2-18).

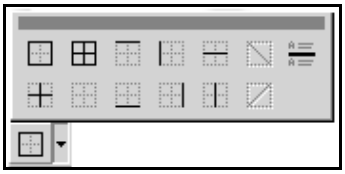


Figure 2-18: Table Border Selection Tool

1. Highlight the table you wish to set the borders for.

2. Click the border icon. A drop down box with border options opens (Figure 2-18).

3. To add or remove the top, bottom, right, left or internal border, click the icon that shows the border to be added or eliminated.

2.5.5 Shading a Table

It is easier to read a table if every other row is a slightly different shade.

1. Highlight the first row you wish to shade.

2. Click the Format option on the menu bar.
3. Click the Borders and Shading option on the Format menu. The Borders and Shading window opens.

4. Click the Shading tab.

5. Click a light shade of gray (gray at 10% or 15%) from the Fill field. Gray at 15% works best if you intend to make photocopies of the document, retaining the shading in the copy but not copying so dark that the text is unreadable.

6. Click the OK button in the Borders and Shading window to return to the table.

7. Position the cursor in the next line you wish to shade and click the  icon (repeat).

Continue with this procedure until all lines that require shading have been formatted. The end result will look similar to Figure 2-19.

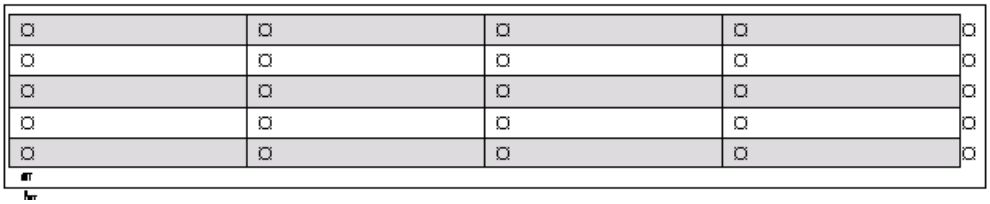


Figure 2-19: Shading a Table

2.5.6 Adding or Deleting Rows

Adding and removing rows from a table is a simple process.

To add a row:

1. Move the cursor to the bottom row of the table.
2. Click the  icon (insert row) to add a row to the table.

To remove a row:

1. Position your cursor on any part of a row.
2. Click the  icon (delete row) to delete the row from the table.

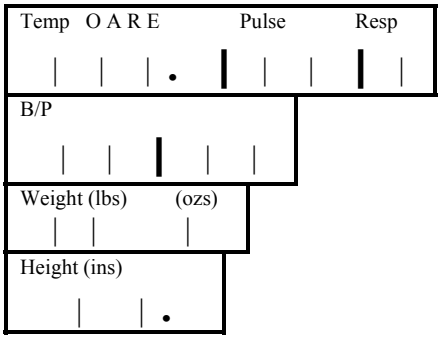
2.5.7 Practice Exercise

Test your skills. Using the techniques you have just learned, recreate the objects shown blow. (Tip: For the vital signs object, begin by putting a table or tables in a text box.)

Item One

GIMC PEDIATRIC CLINIC

Item Two



2.6 Mail Merge

The next procedure to learn is performing a successful mail merge. Mail merge is a method of connecting a Word document to a database. In this case, an encounter form will be connected to patient data, user preferences, and site preferences stored in the PCC database. The secret of this technique is to imbed fields (connections to the PCC database) in the Word document.

2.6.1 Mail Merge Headers

First, attach header and data files to your form to create a mail merge document (Figure 2-20).

1. Click the Tools option from the menu.
2. Click the Mail Merge option on the Tools menu. The Mail Merge Helper window opens.
3. Click the Create button in the Mail Merge Helper window. A drop down menu opens.
4. Click the Form Letters option in the drop down menu. A window opens.
5. Click the Active Window button in the new window. The Mail Merge Helper window returns to the front.
6. Click the Get Data button in the Mail Merge Helper window. A drop down menu opens.
7. Click the Header Options option on the drop menu. The Header Option window opens (Figure 2-21).

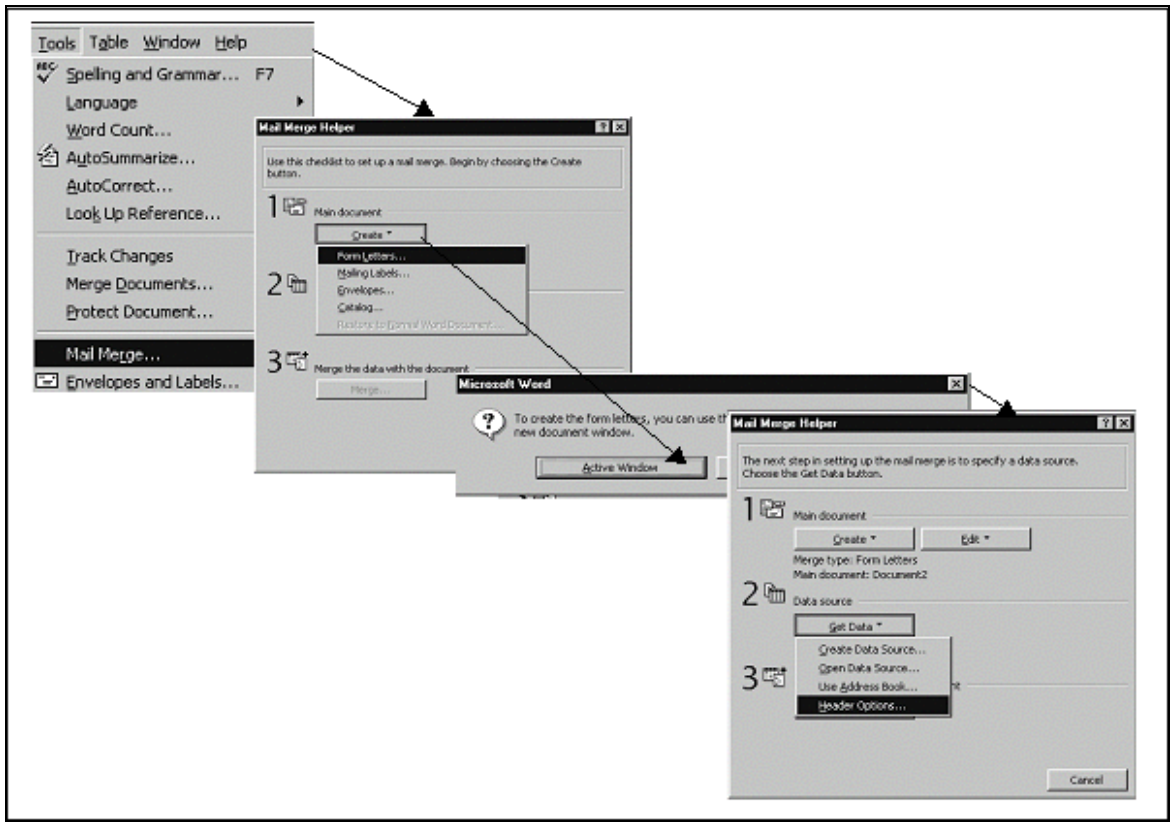


Figure 2-20: Mail Merge, Inserting a Header, Steps 1-7

8. Click the Open button to specify a header. The Open window appears (Figure 2-21).

9. Select the All Files option in the Files of type: field.

10. Select the header source c:\ilc\templates\ef_header.txt.

11. Click the Open button. The Mail Merge Helper window returns to the front.

12. Click the Get Data button on the Mail Merge Helper window again. A drop down menu appears.

13. Click the Open Data Source option on the drop down menu. The Open Data Source window opens.

14. Click the Word Documents option in the Files of type: field.

15. Navigate to the c:\ilc\print\efdata.doc file. The Header Record Delimiters window opens.

16. Select the caret (^) option in the Field delimiter field and click the OK button. The Mail Merge Helper window returns to the front.

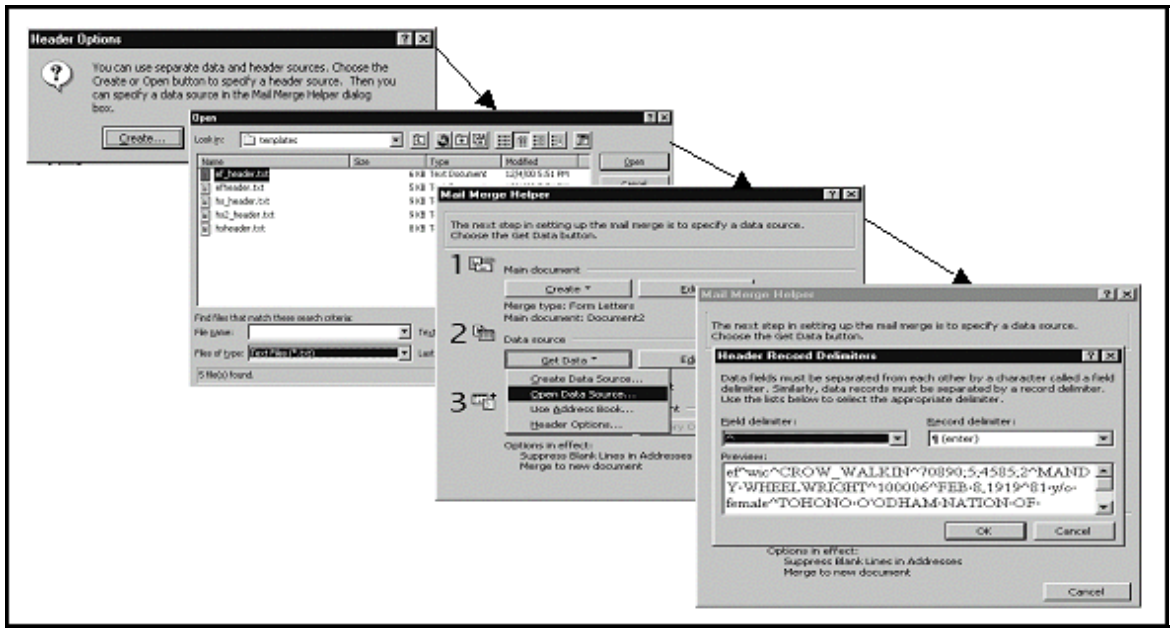


Figure 2-21: Mail Merge, Inserting a Header, Steps 8-16

Click the Close button. The encounter form is now able to use mail merge. The mail merge toolbar should now be visible (Figure 2-22).

Figure 2-22: Mail Merge Toolbar

2.6.2 Fields

The next step is to actually move fields on to the encounter form.

1. Create a text box. With a shaded border, move the cursor to the upper right hand corner of the text box.

2. Click the 

icon on the mail merge toolbar or press the Alt + Shift + F keys. A list of possible fields will appear. Use the page down and arrow keys to easily navigate the lengthy list. (Refer to Appendix B for a full description of this list.)

> **NOTE:** Due to a bug in Word 2000, the Insert Merge Field icon does not work if there are more than 1024 fields attached to the document. Most documents you will work with have at least that many fields. Fortunately, there is a work around. Instead of clicking the icon, use the keyboard option Alt + Shift + F. Another work around is to use Word 97 to design forms. This earlier version of Word does not have the Insert Merge Field bug.

3. Double click on the field name ***patient***. The patient field bracketed by chevron stripes appears in the text box you just created. (See Figure 28.) *Never type in the field name*; e.g., never type the characters "<<patient>>". Always select this field from the list. The field will be inserted at the cursor location.

4. To view the merged component, click on the  icon (view merge data) on the mail merge toolbar. The mail mere fields change to normal text.

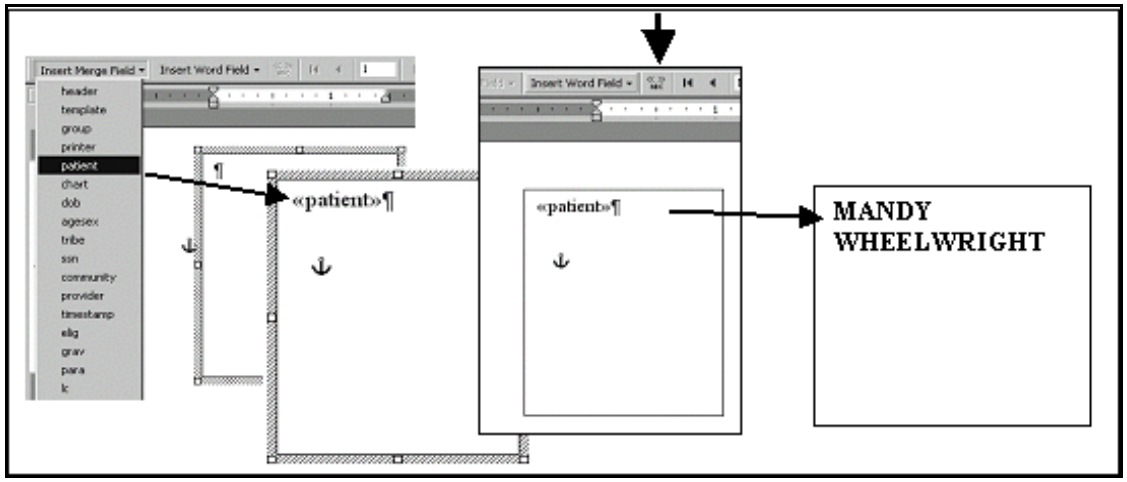


Figure 2-23: Inserting Mail Merge Fields, Steps 1-4

To review the data source, place the cursor anywhere on the page but not inside a table. Click the  icon (edit data source function) located on the Mail Merge toolbar.

If a field value is not present in the database, nothing will print on the form. There will just be a blank space.

2.6.3 Practice Exercise

To practice the information just learned, try the following exercise.

Part One: Follow the steps shown below in Figure.

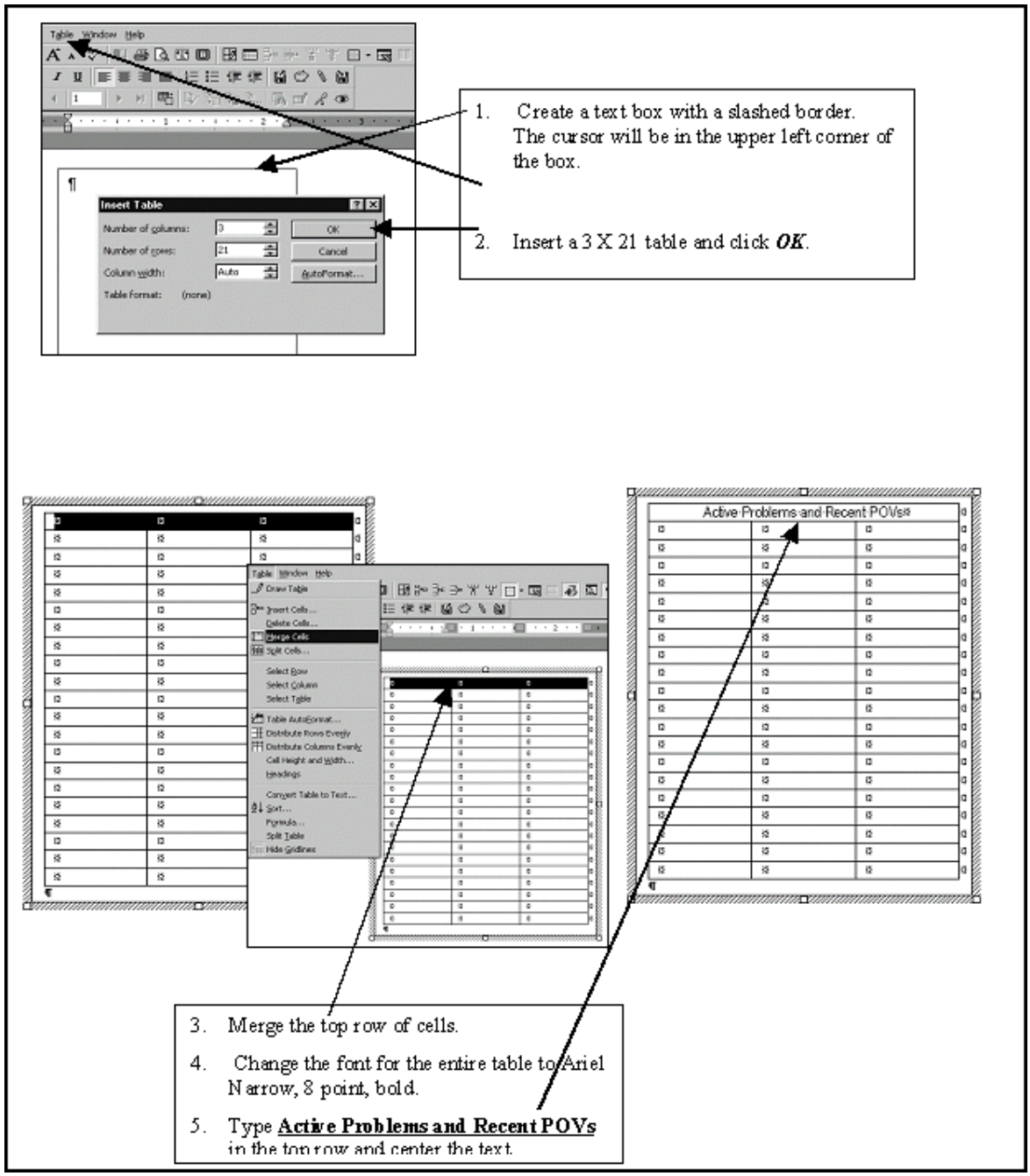


Figure 2-24: Mail Merge Practice Exercise, Part 1

Part Two: Insert the fields p1c-p20c and p1-p20 as shown in Figure 2-25. Then click the merge icon to bring in data from the PCC database as outlined in Figure 2-25.

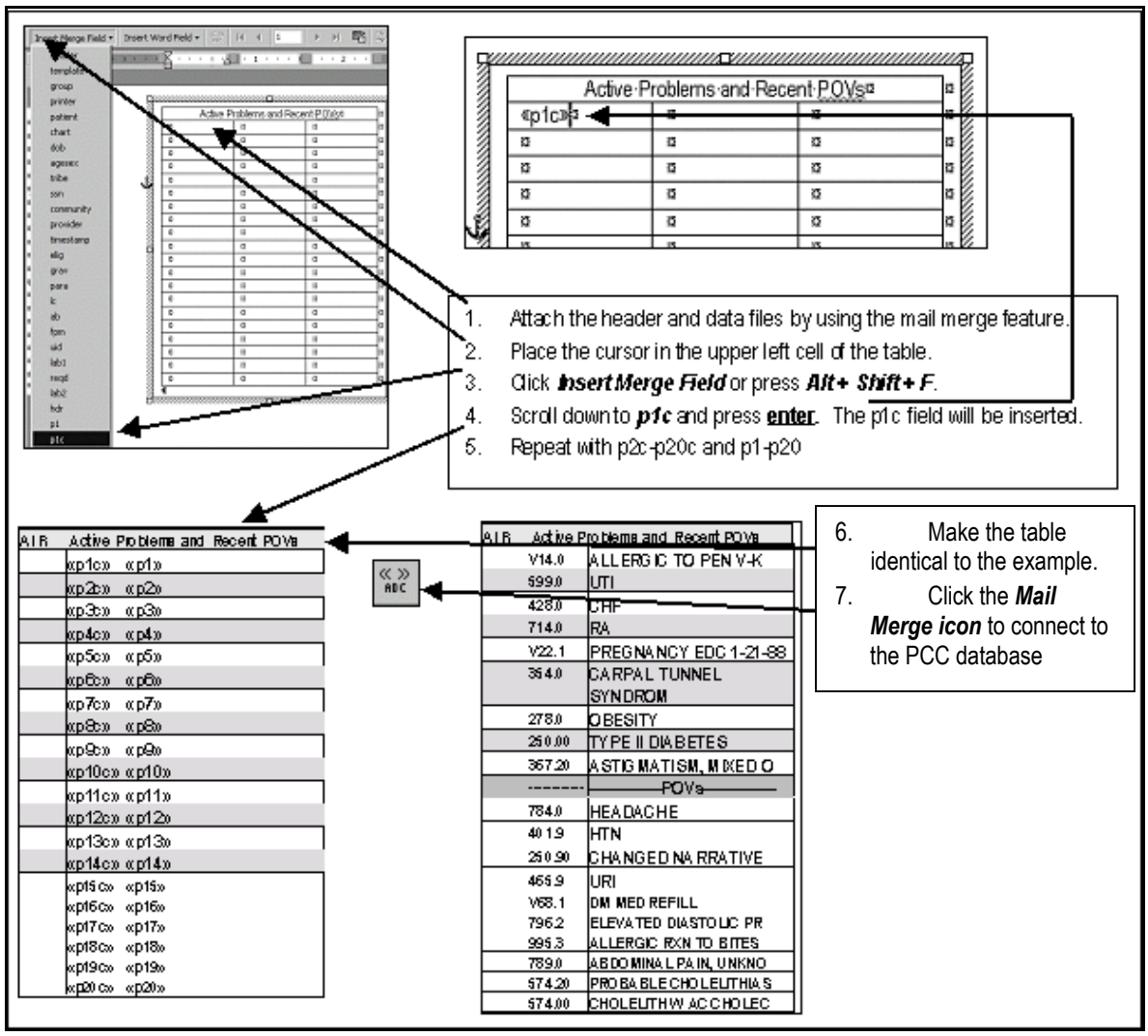


Figure 2-25: Mail Merge Practice Exercise, Part 2

2.7 Copying Components

It is possible to copy pre-existing components from one form and paste them into another. Once the components are copied, they can be accepted "as is" or edited. This approach is much easier than starting from scratch. Two methods of copying components are described below.

2.7.1 Method One

Create a blank document and convert it to notebook paper (line the page).

1. Open a document that contains the components desired (source document). Toggle between the two documents by selecting the Window option on the menu

bar. There is a list of open documents at the bottom of the Window drop-down menu. The document currently in use is marked with a check (Figure 2-26).

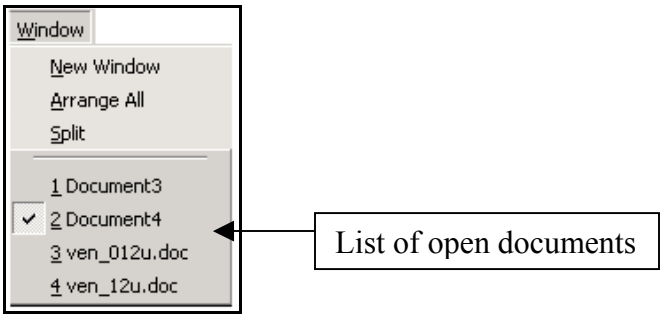


Figure 2-26: Toggling Between Open Documents

2. Go to the source document. Turn off mail merge by clicking on the mail merge icon. The document reverts to a display of only field names bracketed by chevrons. Mail merge must be off before copying and pasting items from the source document to the new document. Now the document is prepared for copying objects—including all of the existing database connections.

3. Highlight the object to be copied from the source document. Click the copy icon (Figure 2-27).

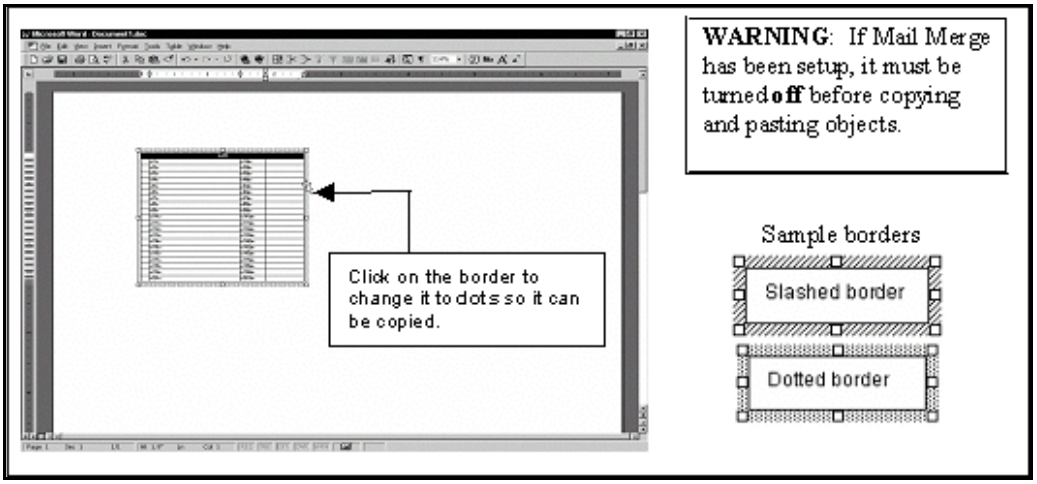


Figure 2-27: Copying Components, Method One

4. Open the new encounter form. Paste object to document by clicking the ***Paste*** icon on the toolbar. Resize the items as needed using the resizing boxes (Figure 2-28).

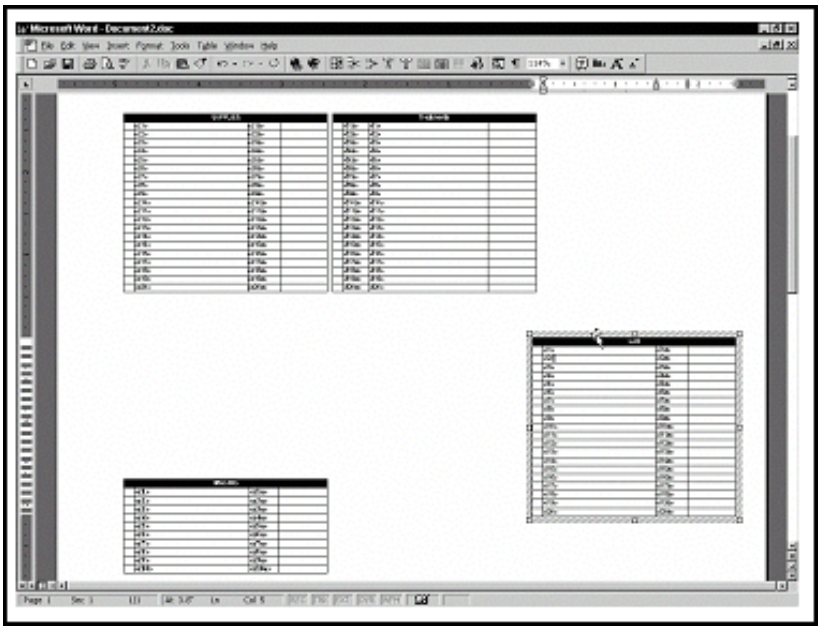


Figure 2-28: Copying Components, Method One, Step 5

2.7.2 Method Two

An alternate way to copy components is to use the drag and drop method. The steps below present an example of how to use this copy method when working with a two-page source document.

1. Open the form that contains the components desired for the new encounter form.
2. Save the document as the name of the new form.
3. Move the cursor to the top of the second page of the form by placing the cursor anywhere on the first page and press the Ctrl + Page Down keys.
4. When the cursor is repositioned, press the Ctrl + Enter keys. This will force the creation of a new blank page after page one.
5. Repeat this process to create a second blank page after the last page of the form.
6. Make notebook paper on both blank pages (line the pages).
7. Click the View option on the menu bar (Figure 2-29).
8. Click the Zoom option. The Zoom pop-up window appears.
9. Click the Many Pages option on the left side of the Zoom pop-up window.
10. Highlight page one and two so that two pages are visible at a time. The idea is to pair a notebook paper (target) page with a source page.

11. Click the OK button at the bottom of the Zoom pop-up window.

12. Highlight the component to be copied.

13. Move the cursor over the slashed border until the cursor turns to four pointers.

14. Right click and drag (i.e., right click and keep holding the right key down – do not release the right key). The border disappears. Keep holding the right mouse key down and drag the component to the lined paper. Release the right key. A pop up window opens when you release the right mouse key.

15. Click the Copy Here option in the pop-up window and the component is copied onto the lined paper.

16. Repeat the process until all required objects are copied on the lined paper. Delete the source pages and fine-tune the target pages.

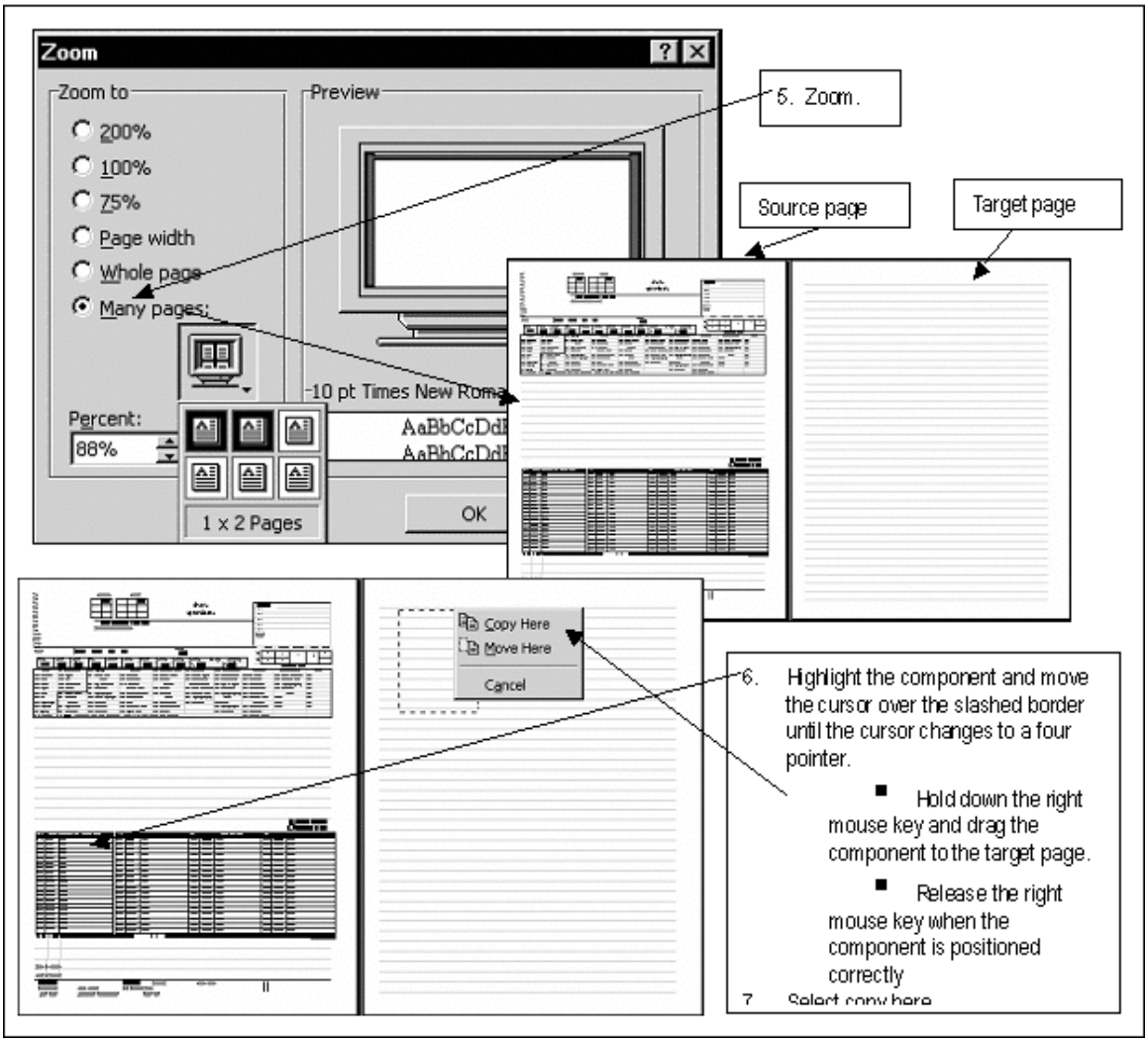


Figure 2-29: Copying Components, Method Two

There are currently dozens of encounter forms that have been developed in the Indian Health Service. Some of these forms are available in the directory c:\ilc\templates. One particularly useful template is wic_template.doc. This template can be attached to the header file ef_header.txt and the data file efdata.doc. Other encounter forms will be made available on the Indian Health Service website. Feel free to use these as a source of components when customizing encounter forms.

3.0 Defining User and Site Preferences

One of the key advantages of the new encounter form is that it can be highly customized to reflect individual patient needs as well as the local clinic needs. Individual providers can specify up to 60 of their preferred diagnoses on a single form. In addition, a provider can develop these preference lists for up to eight different diagnostic categories (infants, children, teen females, teen males, adult females, adult males, senior females, and senior males). This means that each provider can specify up to 480 diagnoses and associated ICD codes.

The site manager can also specify orderables. An orderable is something that can be ordered by a provider, and it is usually associated with a CPT code. There are eight different classes (exams, treatments, injections, radiology exams, injections, supplies, patient education topics and immunizations) that can be specified across four demographic categories (infants, children, adult females, and adult males).

Note that customized lists of diagnoses are provider specific and customized lists of orderables are site-specific. Different sets of utilities are used to maintain the lists of preferred diagnoses and preferred orderables. This section describes how lists of preferred diagnoses and orderables are generated, edited, and saved.

3.1 ICD9 Preferences: Diagnoses

The PCC+ package contains several utilities for generating, editing and saving lists of diagnostic preferences. A list of preferred diagnoses is generated in three stages:

1. The site manager invokes special RPMS data mining software to extract the top 100 diagnoses for individual providers, specific provider groups (e.g., pediatricians) and/or all providers at the site.

2. This list is refined and edited using a version of Microsoft Excel that is enhanced with special macros (Windows-based utility).

3. The list is exported to the RPMS server where additional refinements can be made using a PCC+ utility (MUMPS-based utility).

The lists are ultimately stored in the file VEN EHP ICD PREFERENCES. The contents of this file determine exactly what is printed in the preferred diagnoses section of the encounter form.

3.1.1 Mining the RPMS System for User ICD Preferences

From the PCC+ Managers Menu:

1. Type EXTR at the Select Manager's menu for encounter form Option: prompt.

2. Type the date to begin the search with at the Enter Beginning Date: prompt.

3. Type the date to end the search with at the Enter Ending Date: prompt.

   The duration of the date range determines the size of the sample. If extracting data for all providers at a large medical center, a 30-day range (T-30) should be adequate. If extracting data for a single provider, six months (T-180) or more will suffice.

4. Type the appropriate class (Individual Providers, Provider Groups, or all Providers) at the "Enter Provider Class:" prompt.

5. Select the data source that matches the clinic where PCC+ will initially be implemented. For example, if EH is being set up in the Pediatrics Clinic, select PEDIATRICIANS. If the PCC+ is being put in a general clinic, select PHYSICIANS.

You may limit the sample to a specific clinic or generate a sample from all clinics.

6. Type Y at the Are You Sure You Want To Proceed? Prompt.

   The extraction process takes anywhere from 3 – 30 minutes, depending on the sample size and processor speed. If another search is run, it overrides the first.

   This process generates the raw list for the designated provider(s) of the top 100 diagnoses across eight demographic categories (i.e., a list of 800 diagnoses). The extraction process stores this list in a file named ilc_icd1.txt. The location of this file is determined by the value of FIELD 12 (PATH TO SITE PREFERENCES) in the VEN EHP CONFIGURATION FILE. Typically, if the RPMS is running on the Windows operating system, the path is C:\ILC\. If RPMS is running under UNIX, the path is /usr/spool/uucppublic/ilc/codes. Check with your site manager to be sure of your site's chosen file/ path name.

FTP the file to c:\ProgramFiles\ILC\ILC FORMS PRINT SERVICE\CODES\. This places the data on the print server. If this step is not done, a run time error occurs when the ICD codes are imported.

3.1.2 Editing Preferences with Excel

1. Import the raw data and do preliminary edits.

2. Sort the data by demographic group.

3. Export the data to a text file.

Initial experience suggests that up to 40% of the historical codes extracted with this utility are not optimal and therefore require modification. Edit codes with the assistance of an expert coder. Eliminate invalid codes, split single codes into multiple entries to achieve greater specificity, and correct ambiguous or invalid provider narrative.

Step 1: Import ICD Codes

1. Open Excel.

2. Click the ICDImport button to begin the sort process. A list of ICD codes and narratives appears on the screen (Figure 3-1).

   - Column A contains the ICD9 codes. The spreadsheet is sorted by Column A in ascending numeric order.

   - Column B contains the most common provider narrative associated with the code. Column C contains the official ICD9 narrative associated with the code.

   - Ignore column D-M.

3. Auto format the spreadsheet to provide better visibility of the contents of all columns (Figure 3-1).

   - Click the empty cell above the row labeled 1 and to the left of the column labeled A.

   - Click the Format option on the menu bar.

   - Click the Column option on the Format menu. The Column Formatting menu appears.

   - Click the AutoFit Selection option on the Column menu. The column widths are automatically adjusted.

The maximum number of characters allowed for any provider narrative is 27.

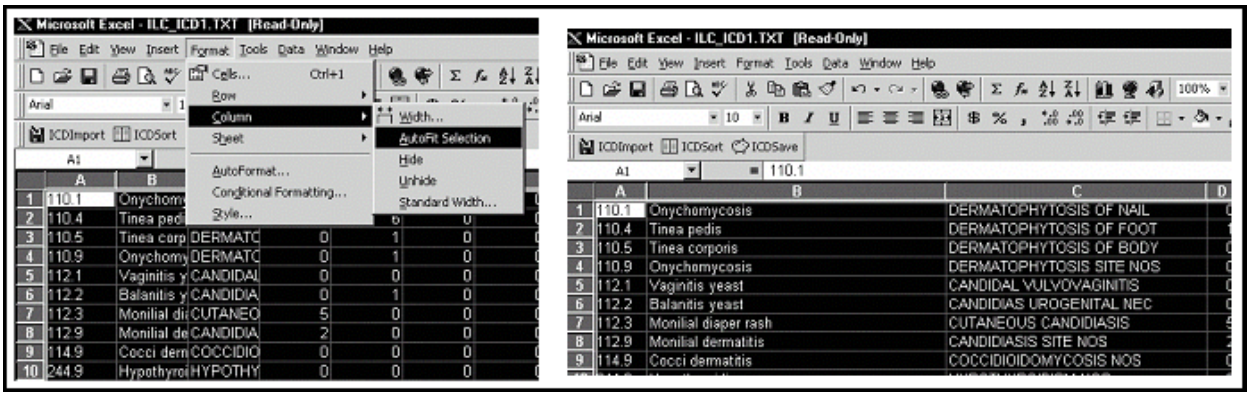


Figure 3-1: Inserting ICD-9 Codes

4. Change any codes necessary (Figure 3-2).

   - Click the cell and type the correction in the text box at the top of the spreadsheet.

Warning: Do not make any changes to columns D-M.

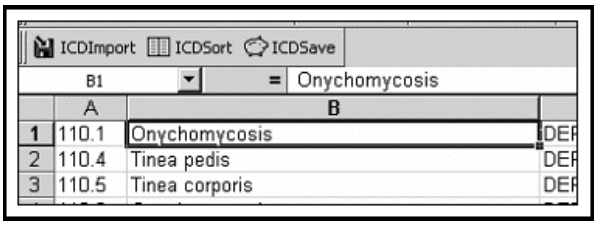


Figure 3-2: Editing ICD-9 Codes

5. Delete any rows necessary (Figure 3-3).

   - Right click on the row number located in the far left hand column. A drop down menu opens.

   - Click the Delete option. The row disappears.

Warning: You may delete rows or edit user narrative / codes, but do not add any rows until the next step.

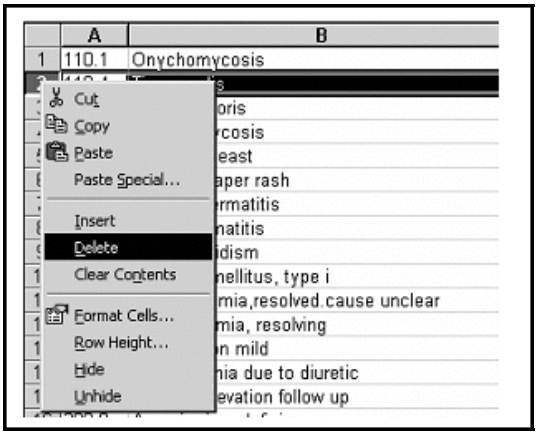


Figure 3-3: Deleting Rows in Excel

6. Save the changes. If you end the editing process to continue it later, be sure to save the file in Excel format as an .xls document. If you save the document as a text (.txt) document, it cannot export your changes and all of the work put into the document up to this point will be lost.

Step 2: Sort ICD Codes

Once the necessary changes have been made, it is time to sort the data.

1. Click the ICDSort button. The data is sorted into eight separate spreadsheets for each category in the following table.

Category	Age Range
Infants	0-2 Years
Pediatrics	2-11 Years

Category	Age Range
Adolescent Female	12-17 Years
Adolescent Male	12-17 Years
Adult Female	18-64 Years
Adult Male	18-64 Years
Senior Female	65+ Years
Senior Make	65+ Years

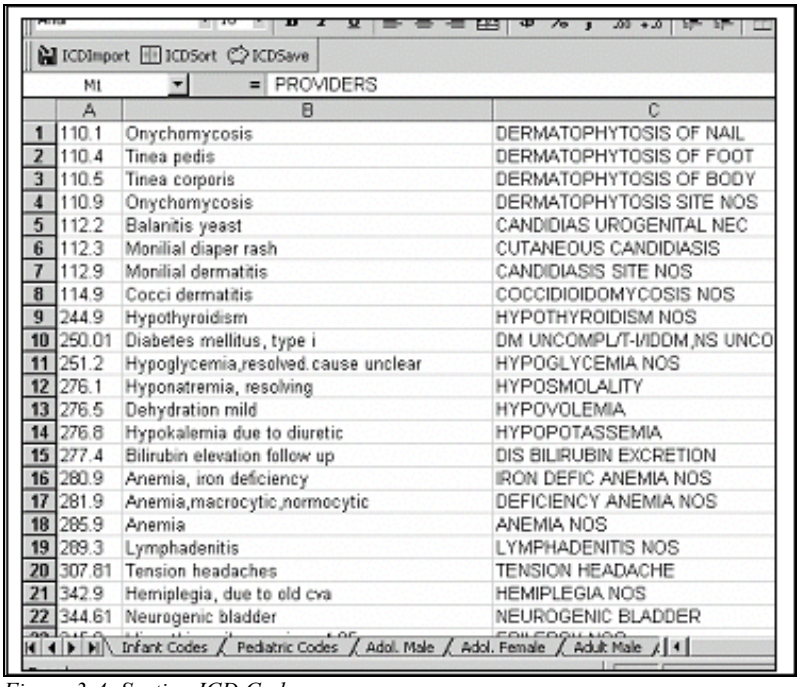


Figure 3-4: Sorting ICD Codes

2. Click the Infant Codes tab.

   - This spreadsheet contains five columns: Column A: ICD code; Column B: code narrative; Column C: official ICD narrative; and Column D: frequency. Ignore column E (Figure 3-4).

   - The maximum number of characters for column B is 27. (Only the first 27 characters from column B will appear on the encounter form.)

   - Note that the spreadsheet is sorted by Column D, the frequency of occurrence in descending order.

3. Edit and delete entries as before.

   - Always insert new entries at row 1.

   - Never make any entries or changes to columns C, D or E.

4. When you have finished adding new entries, delete all rows numbered 55 and higher. The default encounter form can only hold 54 preferences per demographic category.

5. Sort the entries by code or narrative. This step is optional (Figure 3-5).

   - Press the Ctrl + A keys or click on the blank square in the upper left hand corner of the spreadsheet. The entire spreadsheet is highlighted.
   - Click the Data option on the menu bar.
   - Click the Sort option on the Data menu. The Sort window appears.
   - Make sure that the radio button marked "No header row" is selected.
   - Select the column to sort with (A or B) and the sort order (Ascending). Click the OK button and the sort will run.

6. Save the change, if you need to stop the editing process and return later, being sure to save it in Excel format (.xls document). If you save it as a text (.txt) document, you will not be able to export your changes.

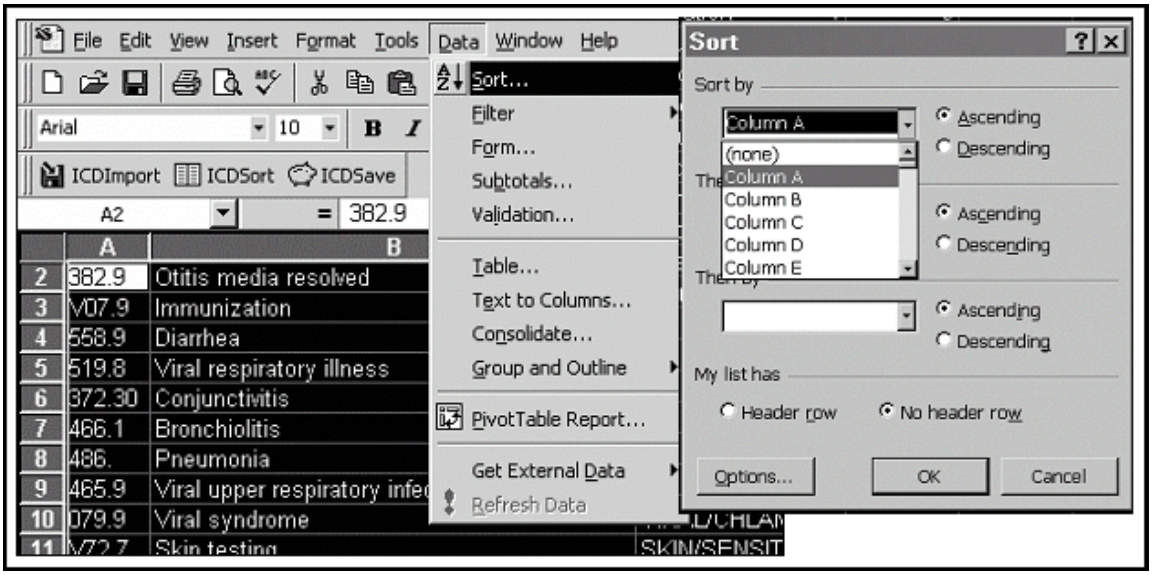


Figure 3-5: Setting Sort Criteria for ICD Codes

7. When the process for the infant spreadsheet is complete, repeat the procedure for the other seven demographic categories. **Ignore the tab marked ICD9 Codes**. Before exporting the data, review each spreadsheet, reduce it to 54 codes, and sort it alphabetically.

Step 3: Export ICD Codes

The final step is to export the codes back to the PCC+ database on the RPMS server. The data resorts itself into one master document. This final sort may take several minutes.

1. Click the ICD Export button. Click the Yes button if you are asked if you wish to replace the existing file IDC_ICD2 (Figure 3-6).

2. Save the changes.

   - Click the Yes button.

   - Click the Save button.

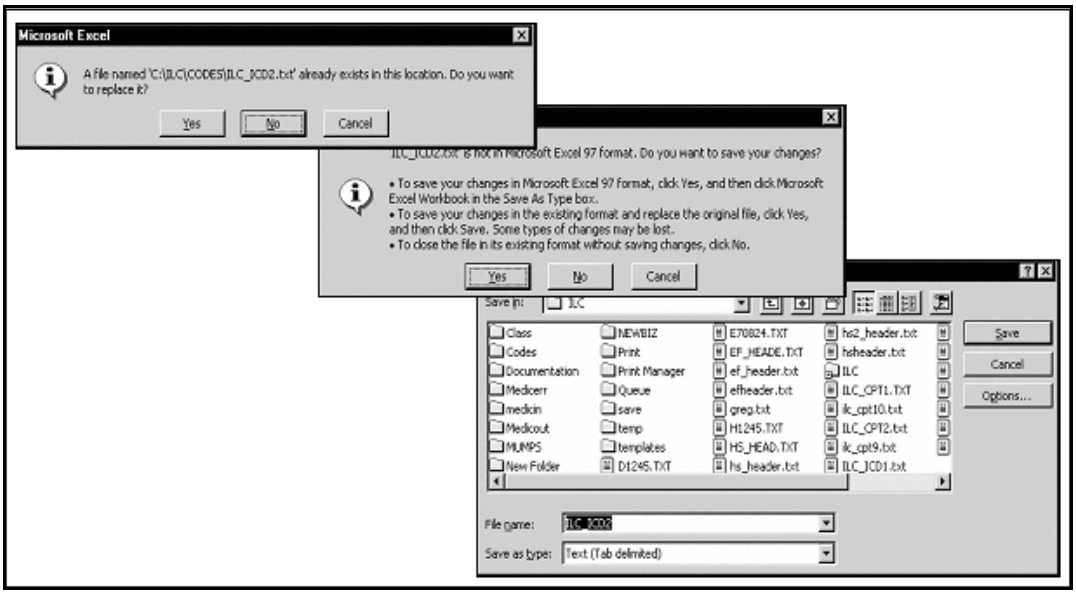


Figure 3-6: Exporting ICD Codes, Steps 1-2

1. Move the file ILC_ICD2.txt, located on the print server in: C:\Program Files\ILC\ILC Forms Print Service\Codes, to the RPMS server using FTP or a floppy disk.

2. If the Server is running UNIX, restore it to the public directory: /usr/spool/uucppublic/. If it is running Windows, restore it to c:\ilc\. This path must match the one recorded in the PATH TO PREFERENCE FILES field of the VEN EHP CONFIGURATION file.

3. Open the menu VENMENU on the RPMS server.

4. Type MGR at the "Select New encounter form Option:" prompt and press the Return key.

5. Type ICD at the "Select Manager's Menu for encounter forms Option:" prompt and press the Return key.

6. Name the provider if asked to assign the preferences to a specific provider. The VEN EHP ICD PREFERENCES file is now populated. This means that provider preferences can now appear on the new encounter form.

3.1.3 Fine Tuning the ICD List

The previous section explained how to mine the RPMS database to extract provider preferences. This section details how to copy preferences from one provider to another and how to customize (add, edit, delete) preferences for final presentation on the encounter form. Begin with the primary menu option, VENMENU, and proceed as follows:

1. Type EDI at the "Select Manager's Menu for encounter forms Option:" prompt and press the Return key (Figure 3-7).

2. Type the encounter form name to be worked on at the "Encounter form name:" prompt and press the Return key.

3. Type the name of the provider whose preferences are to be edited at the "Provider:" prompt and press the Return key.

4. Type the number corresponding to the demographic group at the "Patient group:" prompt and press the Return key. The number of entries allowed and the number of entries selected at this point appear along with the current list of ICD Codes.

5. Type the editing function to be preformed at the "Your choice: (A/E/D/C/S/N/Q):" prompt and press the Return key.

Function	Explanation
ADD	Add a new entry to the list
EDIT	Edit the narrative or ICD code or a single entry in the list.
DELETE	Delete an entry from the list.
COPY	Copy the entries of one provider to another
SUBMIT	Submit the draft list for final entry into the VEN EHP PREFERRED ICD FILE and close the transaction. This item is mandatory. If it is not selected, all edits will be ignored.
NEXT LIST	Open up a new list for editing.
QUIT	Quit this utility

6. Perform the desired edits. Details on performing edits are listed above.

7. Type Y at the "Are you sure everything is OK?:" prompt.

8. Type Submit at the "Your choice: (A/E/D/C/S/N/Q):" prompt and press the Return key.

9. Select the sort option preferred (type A to alphabetize the list, type C to sort the list by code, type S to save the list as is). Press the Return key.

```
Installation Utilities ...
   INS
   MGR    Manager's Menu for encounter forms ...
   PRNT   Print Forms ...

Select New encounter form Option:  MGR

   PRNT   Print Forms ...
   MON    Monitor Print Deamon
   GO     Start Print Deamon
   STOP   Stop the Print Deamon
   ICD    Import ICD Preferences from Excel
   EXTR   Extract Preferences from PCC Database
   SYS    Edit Orderables
   QUE    Monitor the Check-In Queue
   EDI    Edit ICD Preferences

Select Manager's Menu for encounter forms Option: EDI

Encounter form name:    BBC MEDICAL
Provider:    BBC,GENERIC PROVIDER

     Select one of the following:

          1         Infants
          2         Children
          3         Teen Males
          4         Teen Females
          5         Adult Males
          6         Adult Females
          7         Senior Males
          8         Senior Females

Patient group: 1
There is room for 54 entries on this form and you have selected 5 entries
BBC MEDICAL/BBC,GENERIC PROVIDER/Infants

1    Well child exam V20.2
2    URI 465.9
3    Acute superlative otitis media 382.00
4    Cough 786.2
5    Dermatitis 692.9

Select from 'ADD', 'EDIT', 'DELETE', 'COPY', 'SUBMIT', 'NEXT LIST', 'QUIT'
Your choice:  (A/E/D/C/S/N/Q):
```

Figure 3-7: Fine Tuning ICD Selection

Add / Edit a Preference

When adding or editing a preference the provider must specify the diagnostic narrative and the associated ICD code. You can enter any text the provider wants to use or you can use the "official" ICD diagnostic narrative. The first character of the narrative should be capitalized and the rest lower case – unless the narrative is an acronym like 'CHF'. It is legal to enter a partial ICD narrative or code (e.g., 'Sprain of ___' or '382.__'). In this case, the underscore prompts you to fill in the blanks.

Adding a Code

1. Type A (for add) at the "Your choice: (A/E/D/C/S/N/Q):" prompt and press the Return key (Figure 3-8).

2. Type the entry name at the "Name of entry:" prompt and press the Return key.

3. Type the new ICD Code at the "ICD Code:" prompt and press the Return key.

```
Your choice:  (A/E/D/C/S/N/Q): A
Insert new entry at what position? (1 - END of list): END// END of list
Name of entry: Impetigo
ICD Code: 684.

1    Well child exam V20.2
2    URI 465.9
3    Acute otitis media 382.00
4    Cough 786.2
5    Dermatitis 692.9
6    Impetigo 684.

Want to add another entry? Yes// NO  (No)
There is room for 54 entries on this form and you have selected 11 entries
BBC MEDICAL/BBC,GENERIC PROVIDER/Infants
```

Figure 3-8: Adding an ICD Code

Editing a Code

1. Type E (for edit) at the "Your choice: (A/E/D/C/S/N/Q):" prompt and press the Return key (Figure 3-9).

2. Type the position number of the code you wish to edit at the "Edit Entry from what position:" prompt.

3. Edit the name/ narrative information and press the Return key.

4. Edit the ICD code and press the Return key.

```
Your choice:  (A/E/D/C/S/N/Q): EDIT
Edit entry from what position:  (1-56): 3
Name of entry: Acute otitis media  Replace Acute With Acute superlative
Replace
ICD Code: 382.__//

1    Well child exam V20.2
2    URI 465.9
3    Acute superlative otitis media 382.00
4    Cough 786.2
Dermatitis 692.9
Impetigo 684.

Want to edit another entry? Yes// NO  (No)
```

Figure 3-9: Editing an ICD Code

Deleting a Code

1. Type D (for delete) at the "Your choice: (A/E/D/C/S/N/Q):" prompt and press the Return key (Figure 3-10).

2. Type the position number of the code you wish to delete at the "Delete Entry from what position:" prompt.

3. Type Y at the "Sure you want to delete [diagnosis name]?" prompt.

```
Your choice:  (A/E/D/C/S/N/Q): DELETE
Delete entry from what position:  (1-11): 5
Sure you want to delete Dermatitis? Yes//
```

Figure 3-10: Deleting a Code

Copy a Preference

Copying ICD codes through this option means appending entries from another provider to the bottom of the current provider's list.

1. Type C (for copy) at the "Your choice: (A/E/D/C/S/N/Q):" prompt and press the Return key (Figure 3-11).

2. Type the name of the provider you wish to copy the ICD codes from at the "Provider:" prompt.

3. Type the number that corresponds to the patient group you wish to copy the ICD codes from at the "Patient group:" prompt.

4. Type the name of the target list (the list you wish to copy the ICD codes to) at the "Target list:" prompt.

```
Your choice:  (A/E/D/C/S/N/Q): COPY
Enter name of provider to copy from =>
Provider:    IHS,GENERIC PROVIDER

Define the Patient Group to copy from =>

     Select one of the following:

          1         Infants
          2         Children
          3         Teen Males
          4         Teen Females
          5         Adult Males
          6         Adult Females
          7         Senior Males
          8         Senior Females

Patient group: 1
BBC MEDICAL/IHS,GENERIC PROVIDER/Infants
1   Seasonal allergies 477.0
2   Acute bronchitis 466.0
3   Asthma w/o status asthmaticus 493.90
```

```
4   Teething syndrome 520.7
5   Vomiting 787.03
6   Atopic dermatitis 691.8


Target list: BBC MEDICAL/BBC,GENERIC PROVIDER/Infants
There is room for 54 entries on this form and you have selected 11 entries
BBC MEDICAL/BBC,GENERIC PROVIDER/Infants

1    Well child exam V20.2
2    URI 465.9
3    Acute superlative otitis media 382.00
4    Cough 786.2
5    Impetigo 684.
6    Seasonal allergies 477.0
7    Acute bronchitis 466.0
8    Asthma w/o status asthmaticus 493.90
9    Teething syndrome 520.7
10   Vomiting 787.03
11   Atopic dermatitis 691.8
```

Figure 3-11: Copying ICD Codes

Submit a Preference

You must always submit your changes or all editing will be ignored.

```
Your choice:  (A/E/D/C/S/N/Q): SUBMIT
The following list will be saved: BBC MEDICAL/BBC,GENERIC PROVIDER/Infants

1    Well child exam V20.2
2    URI 465.9
3    Acute superlative otitis media 382.00
4    Cough 786.2
5    Impetigo 684.
6    Seasonal allergies 477.0
7    Acute bronchitis 466.0
8    Asthma w/o status asthmaticus 493.90
9    Teething syndrome 520.7
10   Vomiting 787.03
11   Atopic dermatitis 691.8

Are you sure everything is OK? Yes// Y  (Yes)

     Select one of the following:
          A         ALPHABETIZE THE LIST AND SAVE
          C         SORT BY CODE AND SAVE
          S         SAVE
Your choice: A
```

Figure 3-12: Submitting ICD Code Changes/ Additions

3.1.4 Clone ICD9 Preferences

1. Type MGR (Manager's Menu for encounter forms . . .) at the "Select New encounter form Option:" prompt and press the Return key (Figure 3-13). The Manger's Menu will appear.

2. Type CLON (Clone a set of ICD preferences) at the "Select Manager's Menu for encounter forms Option:" prompt and press the Return key.

3. Type the provider name that you'd like to copy the preferences from at the "Copy preferences from:" prompt. Press the Return key.

4. Press the Return key or type YES at the "Are you sure? Yes//" prompt. Wait while the request is processed. When the process is complete, a "DONE!" message will appear on the screen. A cloned entry can then be edited.

```
ILC ENC FORM/HLTH SUMMARY V1.1:  New encounter form
LOCATION:  SELLS HOSPITAL/CLINIC                  USER:  SHORR,GREG
------------------------------------------------------------------

   INS    Installation Utilities ...
   MGR    Manager's Menu for encounter forms ...
   PRNT   Print Forms ...

Select New encounter form Option: MGR
   PRNT   Print Forms ...
   MON    Monitor Print Deamon
   GO     Start Print Deamon
   STOP   Stop the Print Deamon
   ICD    Import ICD Preferences from Excel
   EXTR   Extract Preferences from PCC Database
   SYS    Edit Orderables
   QUE    Monitor the Check-In Queue
   CLON   Clone a set of ICD preferences
   DICD   Delete a users ICD preferences
   EDI    Edit ICD Preferences

Select Manager's Menu for encounter forms Option: CLON

    *****  USER PREFERENCE CLONER FOR DIAGNOSES  *****

Copy preferences from: IHS,GENERIC PROVIDER
Copy preference to: QUICK,SHAWN
Are you sure? Yes// YES
One moment please…..

DONE!
```

Figure 3-13: Clone a Set of ICD Preferences

3.1.5 Delete a User's ICD9 Preferences

1. Type MGR (Manager's Menu for encounter forms . . .) at the "Select New encounter form Option:" prompt and press the Return key (Figure 3-14). The Manger's Menu will appear.

2. Type DICD (Delete a users ICD preferences) at the "Select Manager's Menu for encounter forms Option:" prompt. Press the Return key.

3. Type the provider name that you'd like to delete the preferences from at the "Delete preferences from:" prompt. Press the Return key.

4. Press the Return key or type YES at the "Are you sure? Yes//" prompt. Wait while the request is processed. When the process is complete, a "DONE!" message will appear on the screen.

```
ILC ENC FORM/HLTH SUMMARY V1.1:  New encounter form
LOCATION:  SELLS HOSPITAL/CLINIC                  USER:  SHORR,GREG
------------------------------------------------------------------------


   INS    Installation Utilities ...
   MGR    Manager's Menu for encounter forms ...
   PRNT   Print Forms ...

Select New encounter form Option: MGR

   PRNT   Print Forms ...
   MON    Monitor Print Deamon
   GO     Start Print Deamon
   STOP   Stop the Print Deamon
   ICD    Import ICD Preferences from Excel
   EXTR   Extract Preferences from PCC Database
   SYS    Edit Orderables
   QUE    Monitor the Check-In Queue
   CLON   Clone a set of ICD preferences
   DICD   Delete a users ICD preferences
   EDI    Edit ICD Preferences

Select Manager's Menu for encounter forms Option: DICD

                    *****  DELETE A USERS ICD PREFERENCES  *****


Delete preferences from: QUICK,SHAWN
Are you sure? Yes//
One moment please….
DONE!
```

Figure 3-14: Deleting a User's ICD Preferences

3.2 CPT Preferences: Orderables

The previous section details how to generate a list of provider-specific ICD preferences to customize the encounter form. This section explains how to generate a list of site-specific preferences for orderables to use on the customized encounter form. Orderables include exams, treatments, and supplies. The complete list of orderables can be found in the FileMan file VEN EHP CPT CLASS. The only orderable class not associated with CPT codes is patient education. For patient education topics, use RPMS internal codes.

The process of generating and fine-tuning the lists of orderables is similar to the process of generating lists of provider diagnostic (ICD) preferences with two important exceptions.

- Do not mine the database to generate the list of orderable preferences. These preferences are contained in the table VEN EHP ORDERABLES when the PCC+ package is installed.

- There are only four demographic categories for orderables: infants, children, adult females, and adult males. There are eight demographic categories for diagnostic preferences.

3.2.1 Generating a Standard Set of Orderables

The standard set of orderables is included in the file ven_0110.t2g. (It is not necessary to extract historical data, as with the ICD preferences, to generate the list.) When the globals in this file are restored, the file VEN EHP ORDERABLES will be populated. The contents of this file determine what appears on the encounter form.

3.2.2 Fine Tuning the List of Orderables

The RPMS server-based tools for fine-tuning the list of orderables are virtually identical to the tools for fine-tuning the list of preferred diagnoses (3.1.3).

1. Type MGR at the "Select New encounter form Option:" prompt (Figure 3-15).

2. Type SYS at the "Select Manager's Menu for encounter forms Option:" prompt.

3. Type the encounter form name at the "Encounter form name:" prompt.

4. Type the section of the form to be worked on at the "Section of form:" prompt.

5. Type the name of the patient group to be worked on. From this point on you can add, delete, edit, copy, and submit entries exactly as you did with the ICD preferences.

6. Type the editing function to be performed at the "Your choice: (A/E/D/C/S/N/Q):" prompt and press the Return key.

```
   INS    Installation Utilities ...
   MGR    Manager's Menu for encounter forms ...
   PRNT   Print Forms ...
Select New encounter form Option: MGR

PRNT   Print Forms ...
   MON    Monitor Print Deamon
   GO     Start Print Deamon
   STOP   Stop the Print Deamon
   ICD    Import ICD Preferences from Excel
   EXTR   Extract Preferences from PCC Database
   SYS    Edit Orderables
   QUE    Monitor the Check-In Queue
   EDI    Edit ICD Preferences
Select Manager's Menu for encounter forms Option: SYS

*****  USER PREFERENCE MANAGER  *****

Encounter form name:    BBC MEDICAL
Section of form: ??

Choose from:
   EXAMS
   IMMUNIZATIONS
   INJECTIONS
   LAB TESTS
   PATIENT EDUCATION
   RADIOLOGY EXAMS
   SUPPLIES
   TREATMENTS
Section of form: EXAMS

Select one of the following:
          1         Infants
          2         Children
          3         Adult Males
          4         Adult Females
Patient group: 1
There is room for 10 entries on this form and you have selected 9 entries
BBC/EXAMS/INFANTS

1    DDST 96111
2    EKG 93005
3    Hearing V5008
4    LP 62270
5    PPD 86580
6    Rectal Exam 50605
7    Tympanometry 92567
8    Vision 99173
9    Well Baby Exam

Select from 'ADD', 'EDIT', 'DELETE', 'COPY', 'SUBMIT', 'NEXT LIST', 'QUIT'
Your choice:  (A/E/D/C/S/N/Q):
```

Figure 3-15: Fine Tuning The List Of Orderables, Steps 1 – 6

7. Perform the necessary edits (Figure 3-16).

8. Type Submit at the "Your choice: (A/E/D/C/S/N/Q):" prompt.

9. Select the sort option preferred (type A to alphabetize the list, type C to sort the list by code, type S to save the list as is) at the "Your Choice:" prompt and press the Return key.

```
Select from 'ADD', 'EDIT', 'DELETE', 'COPY', 'SUBMIT', 'NEXT LIST', 'QUIT'
Your choice:  (A/E/D/C/S/N/Q): ADD
You have room for 1 more entry

Insert new entry at what position? (1 - END of list): END// END of list
Name of entry: PDQ
CPT Code: 996111

1    DDST 96111
2    EKG 93005
3    Hearing V5008
4    LP 62270
5    PPD 86580
6    Rectal Exam 50605
7    Tympanometry 92567
8    Vision 99173
9    Well Baby Exam
10   PDQ 996111

Want to add another entry? Yes// NO
Select from 'ADD', 'EDIT', 'DELETE', 'COPY', 'SUBMIT', 'NEXT LIST', 'QUIT'
Your choice:  (A/E/D/C/S/N/Q): SUBMIT
The following list will be saved: BBC/EXAMS/INFANTS
Are you sure everything is OK? Yes// YES

     Select one of the following:
          A         ALPHABETIZE THE LIST AND SAVE
          C         SORT BY CODE AND SAVE
          S         SAVE
Your choice: A
```

Figure 3-16: Fine Tuning The List Of Orderables, Steps 7 – 9

3.2.3 Number of Entries Allowed

The maximum possible number of preferences that can be included on the form is shown in parentheses in the second column of Figure 50. This number is limited by the contents of the header file ef_header.txt. Customized forms may contain fewer entries. For each category (lab, immunizations etc.), the actual number of preferences included on any given from is stored in the encounter from file. For example, a Walk-in Medical Form may only have 54 diagnostic preferences shown on the form, but the form designer could have included up to 60 items.

Header	Parameter	Description
PRB	Max Problems (20)	The maximum number of active problems and past purposes of visit allowed on this form
POV	Max Diagnostic Preferences (60)	The maximum number of diagnostic purpose of visit preferences allowed on this form (ICD codes)

Header	Parameter	Description
EXA	Max Diagnostic Exams (20)	The maximum number of diagnostic exams allowed on this form.(CPT codes)
IMM	Max Immunizations (10)	The maximum number of diagnostic exams allowed on this form.(CPT codes)
INJ	Max Injectables (20)	The maximum number of injectables allowed on this form.(CPT codes)
LAB	Max Lab Tests (20)	The maximum number of lab test allowed on this form.(CPT codes)
EDU	Max Patient Education Topics (20)	The maximum number of patient education topics allowed on this form.(CPT codes)
RAD	Max Radiological Exams (25)	The maximum number of radiological exams allowed on this form.(CPT codes)
SUP	Max Supplies (15)	The maximum number of supplies allowed on this form.(CPT codes)
TRT	Max Treatments (20)	The maximum number of treatments allowed on this form.(CPT codes)

Figure 3-17: Orderables

3.2.4 Create Multiple Order Sets Via Cloning

An "order set" consists of a related group of orderables (immunizations, lab tests, radiology exams, etc.). Each order set is composed of four demographic subsets: infants, children, adult males, and adult females.

PCC+ Version 1.1 was only capable of utilizing a *single* order set covering the four demographic groups. Version 1.2 is capable of utilizing *multiple* order sets, and each individual order set can be associated with specified encounter form templates. For example an order set can be created for the internal medicine template. This order set can be different than the one associated with family medicine template. Many sites may not have a real need for multiple order sets. If you site is one of these, stop now. Order sets are a totally optional feature of PCC+.

To create a new order set, begin by cloning an existing set of orders. The very first time you do this, the primary set of orders (the order set that is distributed with PCC+) will be automatically initialized so that it can be cloned. From that point on, all encounter form templates must be associated with a defined order set. During initialization, all existing templates will be automatically associated with the primary order set. These associations can be changed at a later time if you wish. Once a new set of orders is produced by cloning, it can be edited in the usual to differentiate it from its parent. Experience has shown that cloning/editing process is usually a better way to produce a new order than starting with a blank slate.

If an order set is no longer needed, it can be deleted. If all order sets but one have been deleted, PCC+ will automatically revert to its "pristine state" where no templates are

linked to the primary order set. If at a later time, the order set is cloned, the links will be re-established as described above.

The following figure show how the cloning process is completed. Begin at the PCC+ Managers Menu.

```
   CLON   Clone a set of ICD preferences
   CORD   Clone Orderable Set
   DICD   Delete a users ICD preferences
   DORD   Delete an Orderable Set
   EDI    Edit ICD Preferences
   RES    Reset and restart PCC+
Select Manager's Menu for encounter forms Option: CORD
No order sets have been created yet...
You must initialize the primary order set before it can be cloned.
Want to initialize the primary order set? Yes//   (Yes)
Name of primary orderable set: INTERNAL MEDICINE CLINIC
  Are you adding 'INTERNAL MEDICINE CLINIC' as
    a new VEN EHP ORDERABLE SET (the 2ND)? Y  (Yes)

OK, all current orderables will be associated with INTERNAL MEDICINE CLINIC
All existing templates will be linked to this order set as well
In the future, all new templates must be linked to an order set
Are you sure you want to go on? Yes//   (Yes)
One moment please.....................
Done!
Enter the name of the new Set of Orderables:
------------------------------------------------------------------------
   CLON   Clone a set of ICD preferences
   CORD   Clone Orderable Set
   DICD   Delete a users ICD preferences
   DORD   Delete an Orderable Set
   EDI    Edit ICD Preferences
   RES    Reset and restart PCC+
Select Manager's Menu for encounter forms Option: DORD
Delete what order set: ??
Choose from:
   GENERIC
   INTERNAL MEDICINE CLINIC
Delete what order set: INTERNAL MEDICINE CLINIC
Are you sure you want to delete this orderable set? Yes//   (Yes)
Orderable set deleted!
The following templates are no longer linked to an order set:
     WARM SPRINGS MEDICAL
     CROW TEST
     TEST
     BBH WALKIN CLINIC
Press any key to continue:
```

Figure 3-18: Creating Multiple Order Sets

4.0 How to Generate Documents

This section is for the front desk clerk. It describes how to use the PCC+ check-in module that generates all the new documents. A formal check-in process is required to generate an encounter form, health summary, and Outguide. The module presents the clerk with a short series of questions related to patient demographics, third party coverage, and form generation. When the transaction is completed, a background job is initiated on the RPMS Server that creates a visit (see note below) plus visit control number and initiates the processes of data extraction and printing. The check in process is initiated by selecting a menu item. This presents a simple dialogue wherein the clerk identifies the patient, updates demographic and insurance information, identifies clinic and provider, and specifies encounter form and health summary. The final step is to request an outguide. You can monitor the check-in process remotely.

> **NOTE**: All clinical information in the PCC is associated with a specific "visit." In most cases the visit is an outpatient or field encounter by a provider. The check-in module creates a visit "stub" that is used to integrate clinical and billing information. Data entry of a diagnosis and provider causes the creation of an official visit. The stub serves as a placeholder until the data entry is complete. Each visit is assigned a visit control number (VCN) that is used when recording billable services.

4.1 Selecting a Menu Item

All check-in clerks should receive a key from the site manager to view the PCC+ check-in menu.

```
ILC ENC FORM/HLTH SUMMARY V1.1:  Print Forms
LOCATION:  SELLS HOSPITAL/CLINIC                  USER:  SHARP, MARTIN
-------------------------------------------------------------------------
   ALL    Print encounter form, health summary, Outguide
   EF     Print encounter form
   HS     Print health summary
   OG     Print OutGuide in Medical Records
   DEMO   Print Demo (for learning only)

Select Print Forms Option: ALL
```

Figure 4-1: PCC+ Printing Options

The first choice "**ALL**" is the one that is used 99% of the time. The next three choices are for selecting specific documents without printing all three. These three choices are likely to by used by doctors and nurses. Rarely, a document will fail to print properly. The clerk can use these options to reprint the document without creating a new visit. The final choice puts the system in "demo mode" in which a normal dialogue is presented to the user, but no visit is created. If you learn to use the first option, you know how to use the others because choices two through five are simply abbreviated versions of the first.

4.2 Identifying the Patient

The first question in the check-in dialogue asks you to identify the patient. Enter the name in the format LASTNAME,FIRSTNAME. Note that there is no space after the comma. You can also enter a partial name, and you are presented with a short list of choices. An alternate (and perhaps better) approach is to ask the patient for his/her date of birth and enter this value. A short list of names is returned. Select the one you want. If you know the patient's chart number or SSN, these can be entered as well. If you use the SNN, enter it as an integer with no spaces. The date of birth can be in any common date format.

```
Select Print Forms Option: ALL  Print encounter form, health summary,
Outguide
Welcome to the PATIENT CHECK-IN MODULE....

Patient:    WATERMAN,RAE              F 11-10-60 000120001   SE 100003
                          OR
Patient:    WATERMAN,R
                          OR
Patient:    11/10/60
                          OR
Patient:    100003
                          OR
Patient:    000120001
```

Figure 4-2: Alternate Methods of Selecting a Patient

After identifying the patient, you may be asked if you want to update demographic and insurance information. Some sites elect not to enable this function. If you are using a demo patient, this question is skipped.

```
Update demographics/insurance info? Yes// YES
Patient: WATERMAN,RAE
     SSN: 000120001
     HOME PHONE: 602-555-0001
     OFFICE PHONE:

     Address: 777 N. 33RD ST.
              DOUGLAS, ARIZONA 88776
SSN, Phone or Address Change? N//

     Private Ins.:
          BLUE CROSS
 (Policy Holder:  )  MAY 27, 1990  to
Any 3rd Party Rescource Changes? N//

     Employer:    Status: FULL-TIME
Any Changes in Employment? N//
```

Answer Yes to edit values

Figure 4-3: Editing Patient Demographics, Insurance, and Employment Information

As you can see, it is possible to edit three sections: demographics, private insurance and employment. If you want to change any values, type YES.

4.3 Specifying Clinic and Provider

By specifying the clinic and provider, you determine where the forms are to be printed and how they are to be customized by provider preferences. When in doubt, type a ?? to see the possible choices. Provider names must be entered in the format: LASTNAME,FIRSTNAME.

```
Clinic: // ??

Choose from:
   PEDIATRICS
   CHART REVIEW
   WALK IN
   TELEPHONE ENCOUNTER

Clinic: WALK IN//
Provider for this visit: SHORR,GREG//
```

Figure 4-4: Select Clinic and Provider

Some sites allow telephone and chart review encounters as shown above. These may be associated with special encounter forms. A visit is created regardless of what type of clinic is selected, but no bill is generated if either CHART REVIEW or TELEPHONE ENCOUNTER is selected.

4.4 Specify Encounter Form Type And Health Summary Type

Type ?? to view your local list of encounter forms. If the clinic you selected has a default form, it is printed before the //. The choices for health summaries come from the standard PCC distribution. The most commonly used summaries are ADULT REGULAR and PEDIATRIC.

```
Encounter form: MEDICAL// ??

Choose from:
   DENTAL
   MEDICAL
   OPTICAL
   PODIATRY

Encounter form: MEDICAL//  MEDICAL
Health summary type: ADULT REGULAR// PEDIATRIC
Print outguide/Pull chart? Yes// YES
```

Figure 4-5: Select Encounter Form And Health Summary—Request an Outguide

4.5 Request an Outguide

At some sites there will be one final question: “Print outguide / Pull chart?” If you type YES, an outguide prints in the Medical Records Department alerting the record clerk to pull the chart.

4.6 Print the Document

At this point, the check-in transaction has been completed and you are prompted to enter another patient. Meanwhile, the requested forms start printing at one or more locations at your facility. This happens automatically. No user intervention is required. All you need to do is complete the check-in process for a patient and PCC+ does the rest. In some settings, all three documents (encounter form, health summary, and outguide) are printed in medical records. At others, the encounter form and health summary print in the destination clinic. Typically, the document starts printing 1-2 minutes after the check-in transaction is completed. However, at sites with older, overloaded RPMS servers, there could be as much as a 10-minute printing delay during peak hours. If this is the case, all applications (e.g., pharmacy and data entry), not just PCC+, are probably running slowly.

If the system encounters a problem; e.g., the printer is out of paper, an error message appears on your screen. Notify the site manager immediately if you see an error message. If you fail to notify the site manager, the entire process will stop. What should you do if a document gets lost or damaged? Just repeat the check in process. A second visit is not created if the patient checks in within six hours of the previous visit to that same clinic.

4.7 Monitor the Check-in Process

A simple menu option enables you to remotely monitor the check-in process at all of your clinics. Specifically, this option does the following:

- For each clinic at your facility, it displays a list of patients who have checked in during the past 6 hours.
- It enables you to remove patients from the list as they are processed by the system of care.
- It shows elapsed waiting times for each patient and the average waiting time for all patients currently on each list.

A permanent record of all patients who checked-in is stored in a PCC+ file. This record could potentially replace the traditional “sign in” sheet found in most clinics.

In a typical scenario, you could have a check-in list displayed on a monitor at the nursing station of walk-in clinic. As patients check in at the front desk, their names are displayed on the monitor along this the waiting time. When a patient arrives at the clinic, the nurse removes the name from the list and prepares the patient to see the provider.

From the Managers Menu, select QUE.

```
PRNT   Print Forms ...
   MON    Monitor Print Deamon
   GO     Start Print Deamon
   STOP   Stop the Print Deamon
   ICD    Import ICD Preferences from Excel
   EXTR   Extract Preferences from PCC Database
   SYS    Edit Orderables
   QUE    Monitor the Check-In Queue
   EDI    Edit ICD Preferences

Select Manager's Menu for encounter forms Option: QUE
Clinic: MEDICAL

Medical patients.  Average waiting time 3 min =>

   1)  WATERMAN,RAE (100003) 5m
   2)  WHEELWRIGHT,MANDY (100006) 4m
   3)  MILLER,SALLY (100010) 2m
   4)  JONES,JODY (100014) 1m

Select a patient (1-4) :1
```

Figure 4-6: Monitor the Check-in Process

Next a list of names appears as shown above. Next to each name is the elapsed time since check in. The list is numerically ordered with the "oldest" fist first and so on. The average waiting time for everyone on the list is shown at the top of the screen. All entries over six hours old are automatically dropped from the list. The list and waiting times are refreshed every sixty seconds or whenever the user presses the <**Enter**> key. If there are more than twenty names on the list, press the <**Enter**> key to see the remaining entries. You can repeatedly press the enter key until you cycle through the entire list to the beginning. Press the caret key (^) to exit the session. If there is no keyboard activity for one hour, the session automatically closes.

You can remove a name from the list. Just type the number of the patient you want to delete and press <**Enter**>. The list is refreshed/reordered without that name, and the total elapsed time for the deleted patient is computed and stored in the QUEUE file.

5.0 How To Use The Encounter Form

This section explains how to fill out the encounter form and use it to its maximum advantage. Because each site uses different forms, this section presents a list of general guidelines rather than a set of specific instructions. The Walk-In Clinic Form is used for demonstration purposes in this section (distributed with the package: wic_template.doc.). Most sites use the components of this document as the building blocks for their own set of forms.

5.1 Background

The Walk-in Clinic Form is a three page, one part (i.e., no copies) form that incorporates elements of the original PCC Encounter form, the Indian Health Service health summary and the Superbill.

> **NOTE**: Some encounter forms may only be one page in length; e.g., the telephone encounter form. For purposes of demonstration, we will use a two page ambulatory form designed for a walk in clinic.

The design principles that follow guided the development of the new encounter form:

- Integrate clinical and billing functions into one form.
- Customize the form based on the characteristics of clinics, users, and patients.
- Create a tool to improve user productivity.
- Support current workflow patterns: registration, visit planning, nurse check-in, clinical care, lab tests, pharmacy, appointments, referrals, data entry / coding, billing (including co-pay), and check out.
- Generate the form in real time on a laser printer to avoid the costs of commercial printing and maintaining an inventory of forms.
- Produce a single part form and thereby eliminate the cost of NCR (carbon-less) copies and the need for a dot matrix, impact printer.

> **NOTE**: In most cases, updating clinic processes/workflow will eliminate the need for copies. In cases where copies are required, scan, fax or digital copier technology can be utilized.

- Print identifying data directly on the form eliminating the need for entering identifiers by hand or with Addressograph® cards.
- Take maximum advantage of Windows and Word printing capabilities.

The resulting document is a customized form that draws the following elements from the database:

- **Patient identifiers**: Name, DOB, age, sex, chart number, tribe, SSN, community.
- **Visit identifiers**: Facility, clinic, scheduled provider, visit ID, timestamp.
- **Clinical information**: Active problems, birth history, current medications.
- **User preferences**: Diagnoses and associated ICD codes.
- **Site preferences**: Treatments, procedures, exams, patient education topics.

Patient identifiers and visit information is updated and/or collected during the check-in process. Clinical information is collected during each visit via the encounter form and stored in the PCC clinical database. The site manager enters user and site preferences as part of the initial user registration process (Section 3.0).

5.2 Overview

The following diagrams provide a general map of the Walk-in Clinic form. The first page is used to record nurse check-in data as well as the subjective, objective, and assessment parts of the SOAP note. The second page is used to record the plan. An optional third page is the patient hand out. This page is used to record instructions and to write a work / school excuse if necessary. All three pages contain patient identifier information. See appendix A (Section 6.0) to view a full size copy of the sample form.

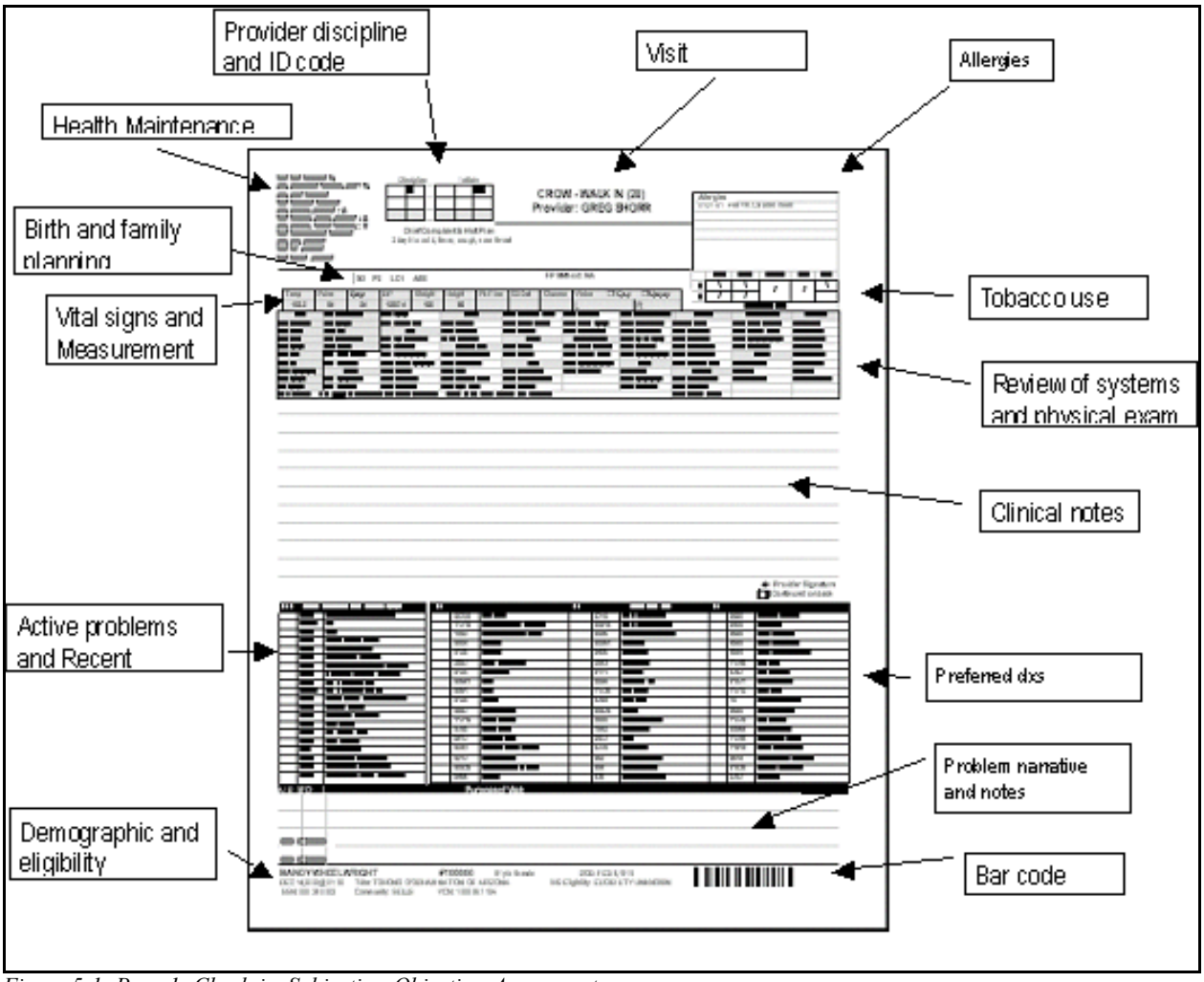


Figure 5-1: Page 1: Check-in, Subjective, Objective, Assessment

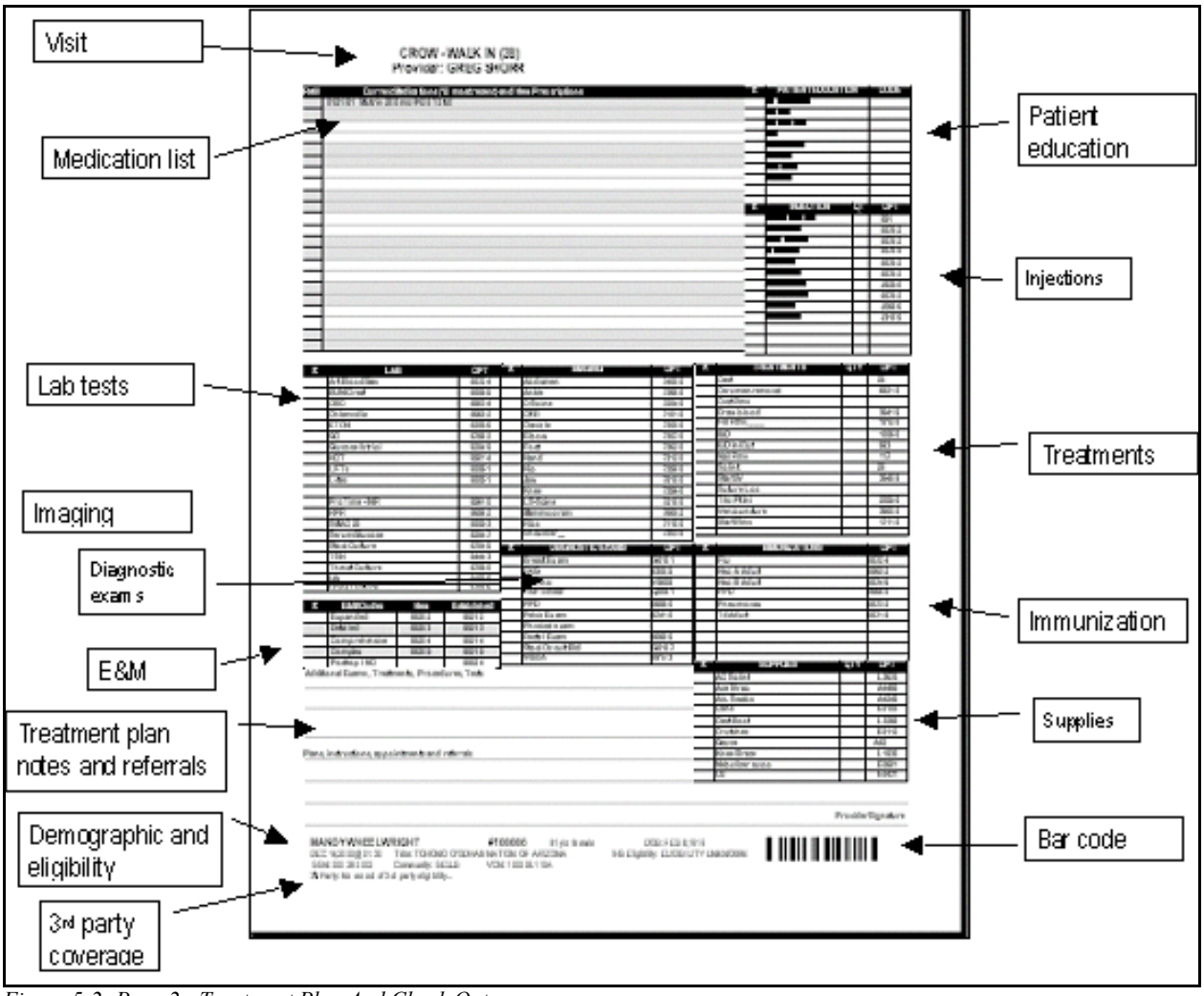


Figure 5-2: Page 2: Treatment Plan And Check Out

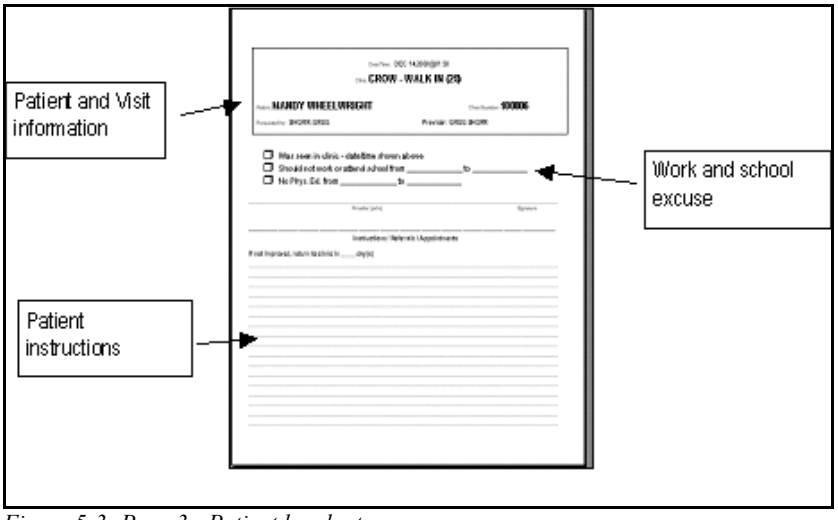


Figure 5-3: Page 3: Patient handout

In addition to being the primary clinical documentation tool, the encounter form is a communication medium between the clinical staff and the data entry clerks and coders.

This document presents a generic approach to data entry, but each site is free to develop their own local conventions.

5.3 Data Entry

Before beginning data entry, confirm that the correct encounter form is being used. Patient identifiers are clearly printed at the bottom of the form. Write legibly using a black ballpoint pen. Black ink is best for scanning and photocopying. Use only those abbreviations that are agreed upon at your facility. If your handwriting is typically illegible, print the diagnoses (the most critical part of the record) to reduce the chance of data entry error and maximize productivity. If the clerk cannot read the information, the form will be sent back to the provider for clarification, wasting valuable time.

5.3.1 Minimum data set

If any of the following data elements are absent, information will not be entered into the database, and the form will be returned to the primary provider for completion.

- Primary provider signature
- Primary provider code (only applies to non-physicians)
- Purpose of visit

All three of these elements must appear on the encounter form.

5.3.2 Excluded data

Virtually everything entered on the encounter form is entered into the database with one important exception — raw subjective and objective notes (see diagram above) are *not* entered. Raw, uncoded narrative is expensive to enter and is of relatively little value except in paperless systems. This is not a paperless system. The PCC is an adjunct to the hard copy record. As a consequence, the legibility of the subjective / objective note is not an issue for data entry. However it remains an important issue for staff communication and for medico-legal reasons.

5.3.3 Additional space

After the initial break-in period, typical users find that they can fit their entire progress notes on the form at least 90% of the time. If additional space is required, continue writing on the back of the form.

5.3.4 Caveats

The PCC electronic patient record is *not* the legal medical record. The computerized data is not intended as a replacement for the chart, but merely an adjunct to the official record. Its purpose is to generate the health summary and manage reports. The patient's hard

copy, written record is still the legal medical chart. On the other hand, the new encounter form is designed to structure the provider's written narrative and coded data in order to assist the data entry staff. The form itself, like traditional progress notes, becomes part of the legal medical record.

As soon as the encounter form is printed, it contains confidential medical information. Therefore, this form should be treated with the same confidentiality as the patient's chart.

The data entry process occurs in four stages.

1. Visit planning
2. Nurse check-in
3. Provider's documentation
4. Closing out the visit

Each stage is associated with a different area of the form. These are discussed in detail in the following sections.

5.4 Visit Planning

Visit planning (VP), sometimes called "industrial strength triage" or "ambulatory case management" is an effective, concurrent quality control process that has been adopted at many outpatient clinics. The primary objective of visit planning is to optimally prepare the patient for the visit and thereby improve patient flow and the quality of care. Visit planning was developed as an extension of the nurse check-in process. It encompasses the following elements:

- **Record validation**: Ensure that all identifiers on all documents match.
- **Initials and start/end time**: Initial the form and write the start time.
- **Record review**: Identify unmet health needs and "open loops" (e.g., find patients who are lost to follow-up). Review and clean up the problem and medication lists, review recent visits (both inpatient and outpatient) and associated diagnoses and plans. Most information required for visit planning is available in the health summary. The record review begins with the summary and, time permitting, moves to the patient's chart. The goal is to check recent visit plans and confirm clinical details.
- **Patient interview**: Identify the chief complaint, current acuity, recent visits outside of the system, chronic disease status and OB / birth information.
- **Orders and Plans** (whenever possible, enter orders to be completed before the patient sees the provider -- this converts waiting time into service time): vital signs, measurements, immunizations, patient setup, special forms, tests, and health maintenance activities.

- Suggested activities for the provider beyond management of the chief complaint (determined by the current workload, unmet health needs, and the patient's wishes).

The new encounter form is specifically designed to support the visit planning process.

5.4.1 Record Validation: Match Patient, Encounter Form, And Chart

Check the demographic identifiers at the bottom of the encounter form and health summary. The first line contains patient information and the bottom line contains visit information. Make sure that these match perfectly with both the patient and the chart. If a mismatch is not detected, an enormous amount of time will be wasted untangling the resulting mess. The Visit Planner is the person responsible for preventing this problem.

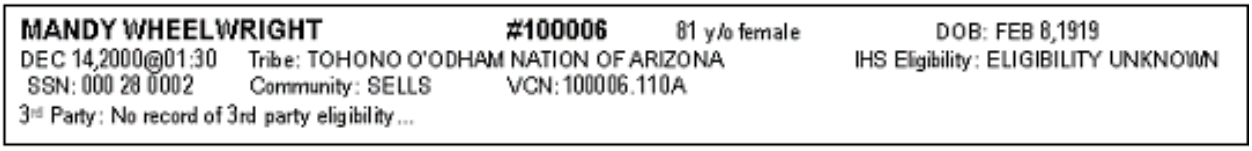


Figure 5-4: Match Patient, Encounter Form, and Chart

5.4.2 Initials and Start/End Time

Each user has a unique, three or four character, identifying code – typically the users initials or an ID number. These must be entered along with the discipline code just as they are on the old PCC form. The ID code is required to insure that the visit planner gets credit for his/her work. An optional time block can be inserted on the form to help system managers track patient flow.

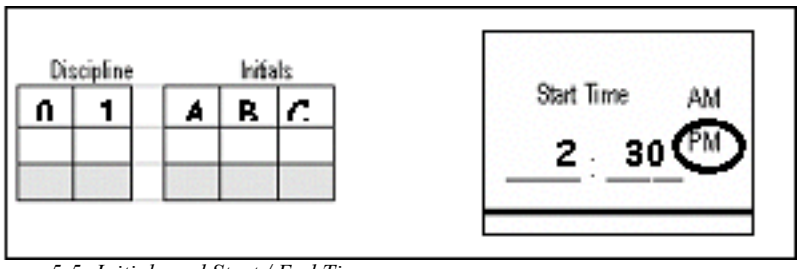


Figure 5-5: Initials and Start / End Time

5.4.3 Record Review

This process should take no more than two to three minutes; do as much as possible in the allotted time. Start with the problem list and the last visit (i.e., the last encounter form in the chart). Then, as time permits, go on to recent visits, hospitalizations, measurements, and health maintenance needs. It is generally recommended that you review the record prior to interviewing the patient; e.g., if the patient has an appointment, review the record on the day before the scheduled visit.

Clean Up the Problem List

The patient's complete problem list is displayed in the health summary. It includes active problems, inactive problems, and associated notes. An abbreviated version of the problem list, active problems only, is printed on the encounter form.

One of the most important visit planning functions is to identify diagnoses that are not on the problem list and add them to the problem list. There are three likely sources of these missing problems:

- Recent outpatient visits
- Recent hospital admissions
- Recent referrals

Information about recent encounters and referrals can be found in the health summary and the chart. The visit planner should check diagnoses in these three areas and, if necessary, add an established diagnosis to the problem list.

If there is space available, an abbreviated list of purposes of visit (POVs) also appears on the encounter form below the active problem list. (Figure 5-6).

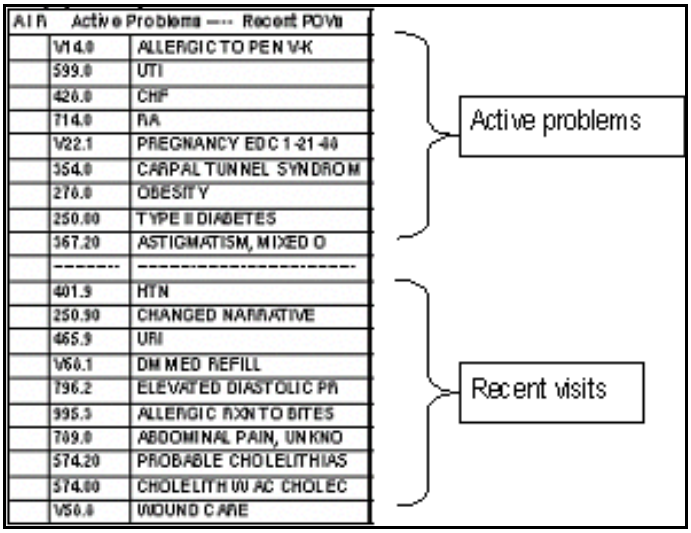


Figure 5-6: Clean Up The Problem List

The list of POVs is non-redundant; that is, it contains no codes from the active problem list and has no repeated codes from the POV list. Therefore, it is not useful for monitoring patterns of care (use the health summary for this purpose). However it is useful for updating the problem list (Figure 5-7).

- Write ***A*** in the left column next to the POV to add an active problem.
- Write ***I*** to add an inactive problem.

- Write ***I*** in the left column next to the active problem code to make an active problem inactive.

- Write ***R*** to remove an active problem.

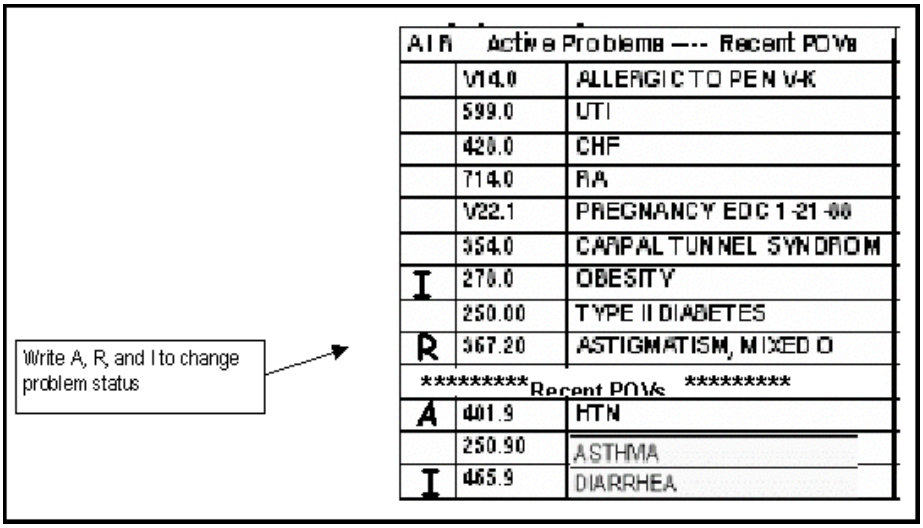


Figure 5-7: Manually Cleaning Up the Problem List

Check Past Measurements

Check the measurements section of the health summary for abnormal results and patterns (for example, unexplained weight change). Unrecognized abnormalities should be reported to the provider as part of the visit plan (Figure 5-8).

Check Health Maintenance Needs

Review the health maintenance section of the health summary to find overdue tests and procedures. Beware of false positives. Many patients may receive health maintenance services at outside facilities, and these may not be documented in you local record system.

The health summary contains records of past health maintenance results and forecasts of due dates for pending events. The encounter form only contains the past history. No forecasts are printed in the current version (Figure 5-8).

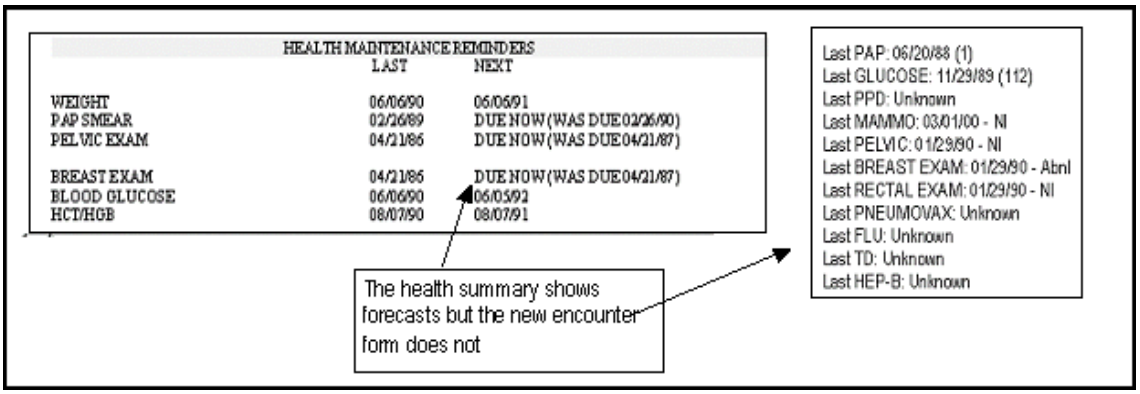


Figure 5-8: Checking Health Maintenance Needs

Review Recent Visits
The Recent Visits and Hospitalizations sections of the health summary provide important information about patterns of care and follow-up continuity. These sections are also a good source of diagnoses that may need to be added to the problem list. Space permitting, an abbreviated list of recent visits is displayed below the abbreviated problem list. Problems and visits are separated by a dashed line.

Identify Scheduled Tests and Exams
Look at the encounter form from the last visit. Determine if any tests or special exams were ordered for this visit. If any tests / exams were completed during the interim, make sure they are on the chart.

5.4.4 Interview The Patient

After reviewing the record, the next visit planning step is to interview the patient. Ask about the chief complaint, allergies, family planning or birth information (if appropriate) and recent health services outside of the local system of care.

Chief Complaint
The interview begins by recording one or more chief complaints on the first line of the visit planning section (Figure 5-9).

Figure 5-9: Chief Complaint

Allergies
If the patient has any allergies, they are listed on the health summary. Allergies are also shown on the encounter form. If the patent has new allergies record them in the box below the old ones.

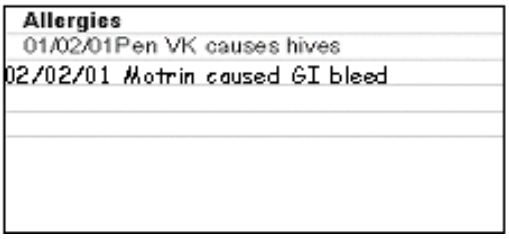


Figure 5-10: Allergies

Reproductive Factors
If the patient is a female between the ages of 12 and 60, the reproductive factors line is printed at the bottom of the visit planning section. It includes space to record LMP, birth history, and current contraception. Add / edit information as shown in Figure 5-11.

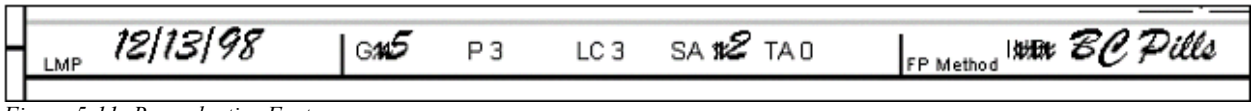


Figure 5-11: Reproductive Factors

Birth Information

If the patient is a child age five or less, the birth history line is printed at the bottom of the visit planning section. This includes birth location, gestational age, one and five minute Apgar scores, birth weight, type of delivery, and complications. Add/edit information as shown in Figure 5-13.

Figure 5-12: Birth Information

Update Test Results and Health Maintenance Activities

Occasionally, tests, treatments, and procedures are done outside of the local system. Record this information without making it appear like the tests were done on this visit. If the patient received services elsewhere, update the immunizations section shown on the second page of the form, including the date, location, and series number. There is not a lot of space, so it may be necessary to overlap adjacent lines. The key is to write legibly so that the coders can read it.

X	IMMUNIZATIONS	CPT
	Flu 11/24/00 Cox Clinic	90724
	Hep A Adult	98632
	Hep B Adult	90746
	PPD	86580
	Pneumovax	90732
	Td Adult	90718

Figure 5-13: Update Test Results And Health Maintenance Activities

Medications

If the patient has had recent visits to outside health care facilities, update the medication list if necessary.

Write a D (for Documentation only) in the Refill column and write the prescription information in the Current Rx section of the encounter form. This tells the coders and pharmacists that this record is not a new prescription but rather updated documentation of an outside prescription.

Refill	Current Medications (12 most recent) and New Prescriptions
	1% Hydrocortisone Cream Rx'd at Cox Clinic 01/02/01

Figure 5-14: Medications

Diagnoses
A convention similar to the one used for medications can be employed to enter outside diagnoses that are not actually managed on this visit (Figure 5-15).

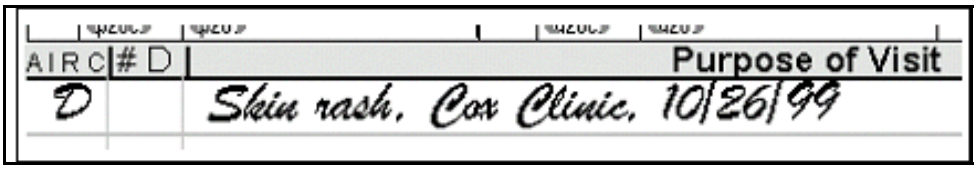


Figure 5-15: Diagnosis

Shortcut: If the diagnosis that needs to be added is included in the ICD Pick List section of the encounter form, write a ***D*** in the column next to the appropriate diagnosis.

Enter the date of the test in the left column of the Visit Plan Orders section. Then enter the location in the right column. Do not circle the item because this implies that you are ordering it today (see next section). An alternative approach is to create a separate box specifically for recording outside services. The box shown below does not appear on the sample form, but feel free to add it (Figure 5-16).

Figure 5-16: Diagnosis Shortcut

Skin Test Results
Record a skin test reading as shown in Figure 5-17. Be sure to initial and date it.

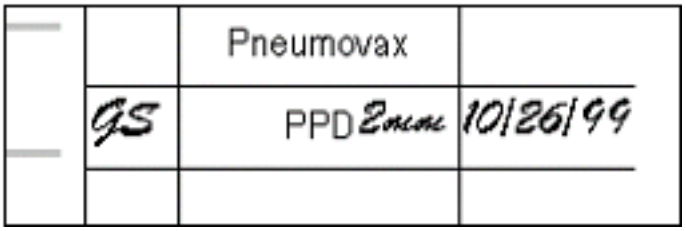


Figure 5-17: Skin Test Results

5.4.5 Orders and Plans for the Visit

The last step is to enter the visit plan itself on the form. On the traditional PCC form, the orderables are in the right hand column. On the new encounter form, the orderables and associated CPT codes take up most of the second page. The orderables are patient-specific (e.g., you will not find childhood immunizations on an adult's form and you will not find PAP smears on a male's form.). The items for any given demographic group are determined by local preferences.

Typical Convention
The visit planner records an order by circling the orderable. The person that actually carries out the order checks it in the left column and initials it to the right of the item (Figure 5-18).

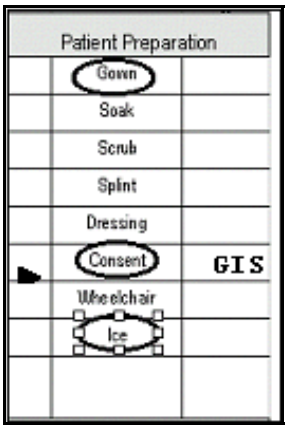
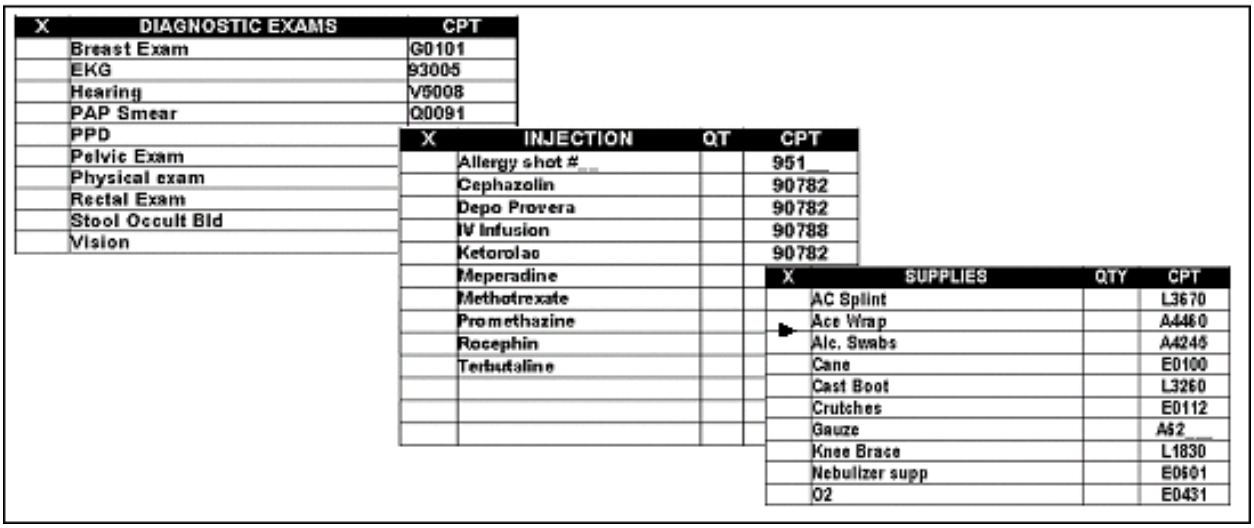


Figure 5-18: Enter Orders And Plans For The Visit

The Patient Prep box shown above is optional and is not shown on the sample form. You may add it to your form so that the visit planner can alert downstream personnel about patient preparation needs.

The second page lists the following orderables: patient education, injections, lab test, radiology exams, treatments, diagnostic exams, immunizations and supplies (Figure 5-19). If the orderable is not present on any list, write in the item on a blank line or in the section marked "Additional exams, procedures, treatments and tests" (Figure 5-20). A few examples are shown below.



X	DIAGNOSTIC EXAMS	CPT
	Breast Exam	G0101
	EKG	93005
	Hearing	V5008
	PAP Smear	Q0091
	PPD	
	Pelvic Exam	
	Physical exam	
	Rectal Exam	
	Stool Occult Bld	
	Vision	

X	INJECTION	QT	CPT
	Allergy shot #__		951__
	Cephazolin		90782
	Depo Provera		90782
	IV Infusion		90788
	Ketorolac		90782
	Meperadine		
	Methotrexate		
	Promethazine		
	Rocephin		
	Terbutaline		

X	SUPPLIES	QTY	CPT
	AC Splint		L3670
	Ace Wrap		A4460
	Alc. Swabs		A4245
	Cane		E0100
	Cast Boot		L3260
	Crutches		E0112
	Gauze		A62__
	Knee Brace		L1830
	Nebulizer supp		E0501
	O2		E0431

Figure 5-19: Orderables

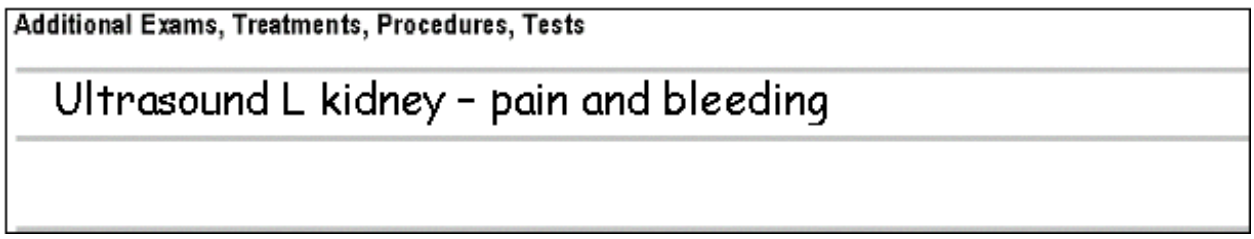


Figure 5-20: Plans for Visit

Note for the Provider
Information found during the visiting planning process that must be passed on to the provider should be included in the chief complaint section (Figure 5-21).

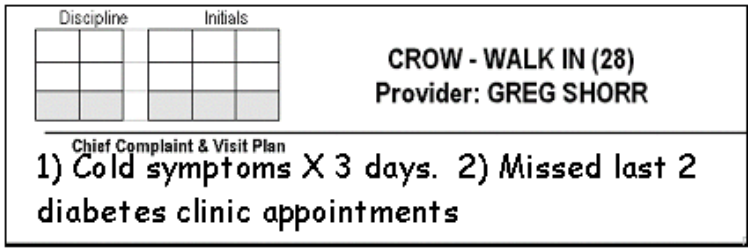


Figure 5-21: Notes for Provider

5.5 Nurse Check-in

After visit planning, the check in nurse takes vital signs, fills out lab slips and put the patient in an exam room.

5.5.1 Enter Vital Signs

Enter vital signs and measurements in the usual way. The sample form uses a horizontal format rather than clustering the vital signs in the upper left corner (Figure 5-22).

Figure 5-22: Vital Signs

5.5.2 Carry Out Orders

Review the second page of items ordered by the visit planner. Remember, the visit planner circles an item and the check in nurse checks it off and initials it when the order is completed.

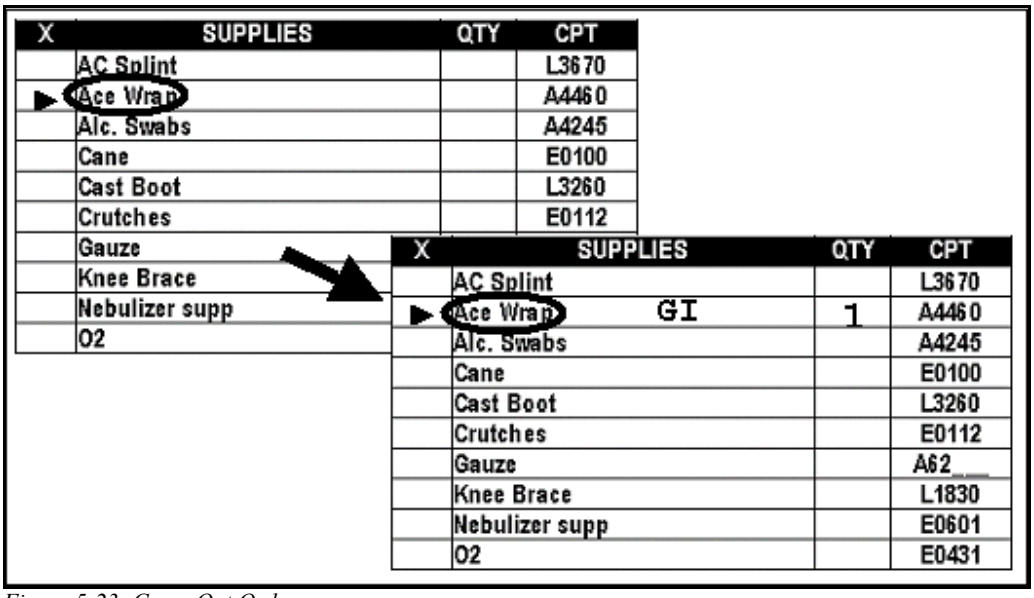


Figure 5-23: Carry Out Orders

5.6 Documentation

The purpose of this section is to teach the provider how to fill out the SOAP note while taking maximum advantage of the encounter form technology. The provider should view the encounter form as a combination superbill and structured progress note. The note is structured rather than free form to help the data entry clerks perform more efficiently.

5.6.1 Validate the Record

Before beginning to fill out the encounter form, make sure that the encounter form, health summary, chart, and patient all match. Check the identifiers on the bottom of all encounter form pages to make sure that they correspond to the chart and health summary.

5.6.2 Review Information for Critical Items

When two health professionals assess a patient's overall health needs, it is more likely that critical items are identified. This approach to visit planning has been shown to improve the quality of care in a variety of settings. Elements of the visit plan are found in the following sections: chief complaint, family planning/birth info, allergies, diagnoses, medications, and orderables.

5.6.3 Use the History and Physical Box

The history and physical exam box has the potential to improve the documentation required to justify E & M code assigned to the visit. It also can reduce overall documentation time and increase third party reimbursement. The H&P box shown on the sample form was developed by Presbyterian Health Services, the largest health care provider in New Mexico, for use in their ambulatory care centers. The box contains two

sections: a review of systems (patient history) and physical findings. The following documentation conventions apply when using the box (Figure 5-24).

- If the item is normal, place a check ✓ by it.
- If it is abnormal, place an **X** by it. All abnormal finding must be described in the soap note.
- Numeric codes can be substituted for item names.

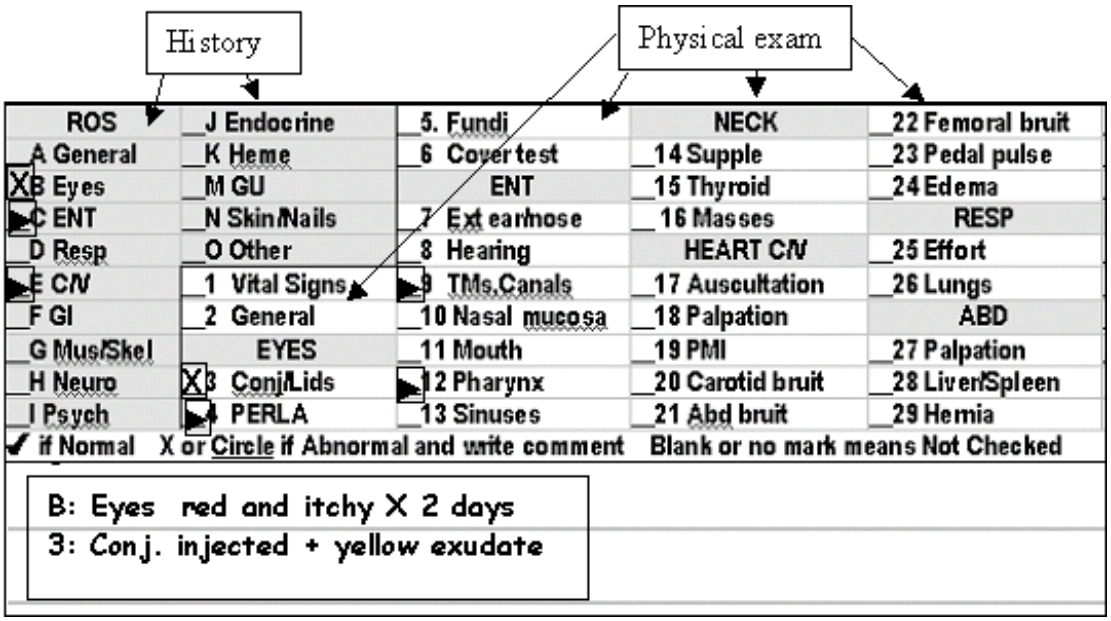


Figure 5-24: History and Physical Box

5.6.4 Enter Purposes of Visit, Diagnoses and Problems

Past experience indicates that 90% of the time, the presenting problems and their associated codes are present on the encounter form. These diagnoses are listed in two adjacent components: the Active Problem/Recent POV list on the left and the Provider Preferences list on the right. Proper use of these lists speed up the documentation process, improve legibility, and reduce coding errors.

A purpose of visit (POV) is a reason for coming to the clinic. Valid reasons include vague symptoms, defined diseases, follow-up activities, tests, medication refills, and other services.

A diagnosis is a clinical assessment made by a health care professional that can be associated with a specific ICD9 code. Examples include headache, hypertension, prenatal care, etc. Many diagnoses (or POVs) may be documented on a single visit and the same diagnosis (or POV) can be entered on repeated visits.

A problem is a construct first defined by Dr. Larry Weed in the 1960s. Dr. Weed, for purposes of documentation, viewed each patient as a collection of clinical and social

problems. Problems were categorized as "active" - currently needing attention, (e.g., hypertension); "inactive" - not currently needing attention yet still clinically significant, (e.g., pregnancy, delivered); and "resolved" (e.g., a healed ankle fracture).

Active and inactive problems are displayed the health summary or on a list which is placed as the first page in the chart. Dr. Weed reasoned that viewing the problem list would be the quickest way to get a comprehensive view of the patient. Apparently, many influential people agreed with him because the problem list is now a required component of every medical record.

Dr. Weed developed a set of guidelines for problem documentation and problem list maintenance. These are reviewed below because the encounter form and computer database were designed to conform to these guidelines.

Definition of a Problem: A problem can be any clinically relevant assessment (e.g., essential hypertension, abusive home environment, refractive error, gingivitis, schizoid personality, RUQ abdominal pain, no transportation available, etc.).

- Each problem is assigned a unique ID number that never changes. In the ILC health summary, the problem number is not a "pure" integer. It is a concatenation of the local two-character site code followed by an accession number. For example if the local site is the Mayo Clinic, the first problem would be MC001, the second MC002, etc.

- The problem narrative can change as the underlying condition evolves (e.g., RUQ abdominal pain changes to acute cholecystitis and then further changes to cholecystectomy. In this case, the problem number remains the same, but the associated problem narrative changes over time).

- A problem must reflect the current state of clinical certainty. Modifiers that reflect uncertainty such as possible, questionable, and probable are not allowed (e.g., "RUQ pain" is a perfectly valid problem narrative, but "Probable cholecystitis" is not valid). The best clinicians are the ones who allow themselves to co-exist with ambiguity and keep an open mind (e.g., the narrative "abdominal pain" and its wide spectrum of possibilities is better than the narrowly focused narrative "probable cholecystitis").

- Problems must be assessments, not plans (e.g., "Rule out cholecystits" is a plan, not a problem). Therefore expressions like R/O and "rule out…" are not allowed in a problem list.

- Once a problem is placed on the list, it remains there forever unless it is resolved and is no longer of clinical significance. Problems must be explicitly removed by a clinician. They never expire automatically.

- Even if the same diagnosis is made on repeated visits, it only appears in the problem list once. No redundancy is allowed in the problem list.

- No minor acute illnesses, routine services, or health maintenance activities should appear as problems (e.g., "URI," "heat rash," "PAP smear," "med refill," etc. should not be written in the problem list)

- If a problem is a chronic disease, include the date of onset in the problem narrative (e.g., "Diabetes Mellitus, Type II. Onset 4/18/93").

Entering the Purposes of Visit: The preferred convention for documenting POVs is simple (Figure 5-25).

- To document the primary POV, circle the narrative and write 1 next to it.

- To document any secondary POV, circle it and write 2 next to it.

Write D in the left column, to signify that the patient had that diagnosis established elsewhere. "D" stands for "documentation only." It is a way to get clinical information in the record without contaminating the billing process.

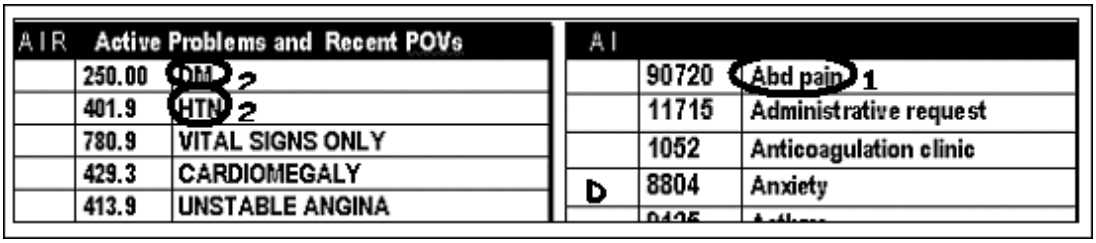


Figure 5-25: Entering the Purpose of Visit

Write problems that do not appear on the form in the POV entry box near the bottom of the page. This box is similar to the one on the traditional PCC form. The only exception is that if any other problems are written in, the number indicating primary or secondary purpose of visit must be written next to the handwritten POV (Figure 5-26).

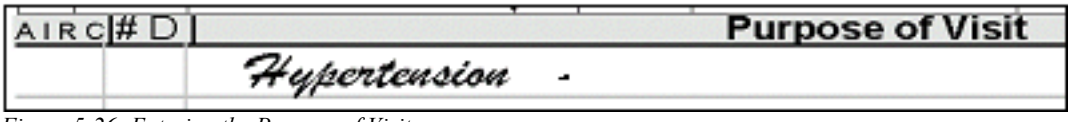


Figure 5-26: Entering the Purpose of Visit

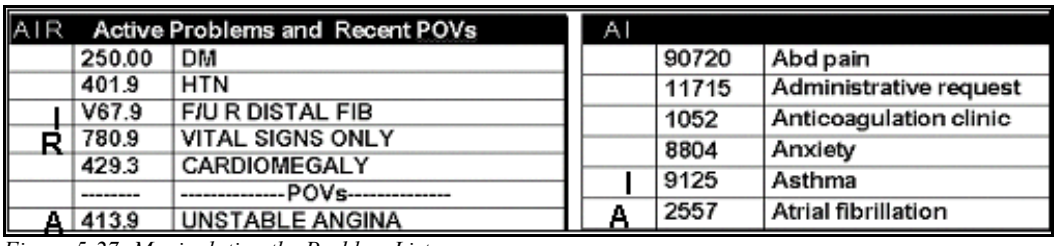
Manipulating the Problem List

- In the Active Problem section, write R in the left column to tell the data entry clerk to remove that problem.

- In the Recent POV and User Preferences sections, write A to tell the clerk to add this diagnosis to the active problem list.

- In any section, write I to designate a problem, POV or diagnosis as inactive.

To add a problem that does not appear on the list, write in your entry in the usual way in the POV narrative section.



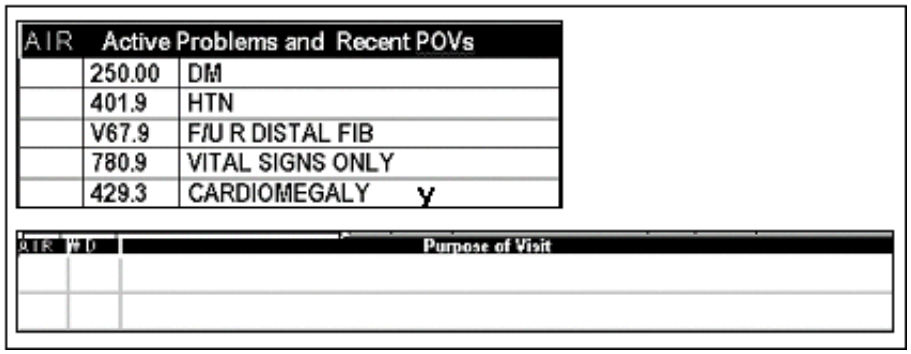
AIR	Active Problems and Recent POVs	
	250.00	DM
	401.9	HTN
I	V67.9	F/U R DISTAL FIB
R	780.9	VITAL SIGNS ONLY
	429.3	CARDIOMEGALY
	--------	----------POVs----------
A	413.9	UNSTABLE ANGINA

AI		
	90720	Abd pain
	11715	Administrative request
	1052	Anticoagulation clinic
	8804	Anxiety
I	9125	Asthma
A	2557	Atrial fibrillation

Figure 5-27: Manipulating the Problem List

- To change the narrative of an active problem, write X next to it. Then, in the space below, write another X in the left column followed by the new narrative. The Xs link the two sections and provide a simple path for the data entry clerk to follow.

- If a second change is required, use the letter Y and so on.



AIR	Active Problems and Recent POVs	
	250.00	DM
	401.9	HTN
	V67.9	F/U R DISTAL FIB
	780.9	VITAL SIGNS ONLY
	429.3	CARDIOMEGALY Y

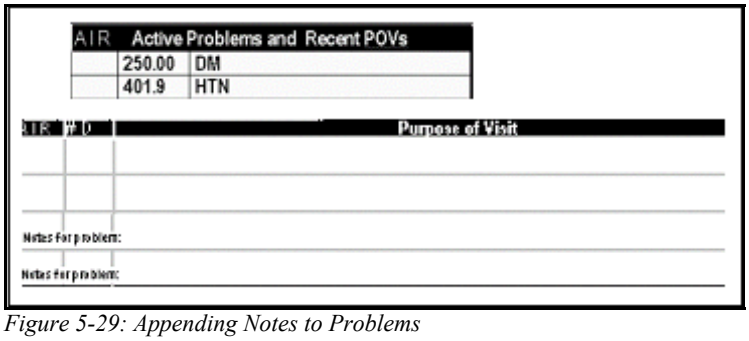
AIR	W	D	Purpose of Visit

Figure 5-28: Manipulating the Problem List

Appending Notes to Problems

- Use the "X" technique described above to append notes to problems.

- To remove a note, find the note number on the health summary. Then write a message to the data entry clerk to remove the note (Figure 5-29).



AIR	Active Problems and Recent POVs	
	250.00	DM
	401.9	HTN

AIR	W	D	Purpose of Visit

Notes For problem:

Notes For problem:

Figure 5-29: Appending Notes to Problems

5.6.5 Enter Medications

The medication list on the encounter form can be configured to display all medications or just the chronic medications.

- To order a refill, the provider signs his/her name next to the prescription and writes the date.

- To edit a refill (i.e., change the quantity dispensed) cross through the old value and write a new one. Initial the change.

New prescriptions can be entered in the space below the old ones.

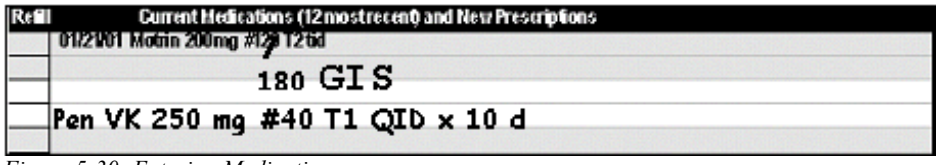


Figure 5-30: Entering Medications

5.6.6 Enter Orders

The new encounter form is designed to improve order communication and charge capture for services rendered. It accomplishes this by extending and customizing the list of orderables on the old PCC encounter form. Take particular notice of the added boxes for patient education, supplies, and imaging.

- To enter an order, just circle it. When nursing personnel carry out the order, they check and initial it.

Items that are not included in any of the orderables lists can be entered by hand in the box near the bottom of the page.

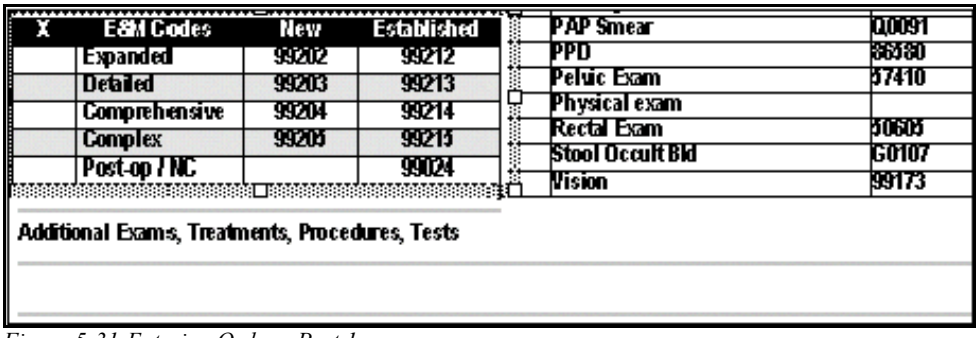


Figure 5-31:Entering Orders, Part 1

5.7 Closing out the Visit

To close out the visit, enter the E&M code, future plans and patient instructions.

5.7.1 Enter the E&M Code

Accurate Evaluation and Management Codes are critical for optimal charge capture. At many IHS sites, the physician must enter the E&M code. The new encounter form has a special box for this purpose (see Figure 88). At most sites the coder – not the provider – fills out this box.

5.7.2 Enter Future Scheduled Encounters and Referrals

There is space to enter future scheduled encounters and referral requests. The same box can be used to document orders for the next visit.

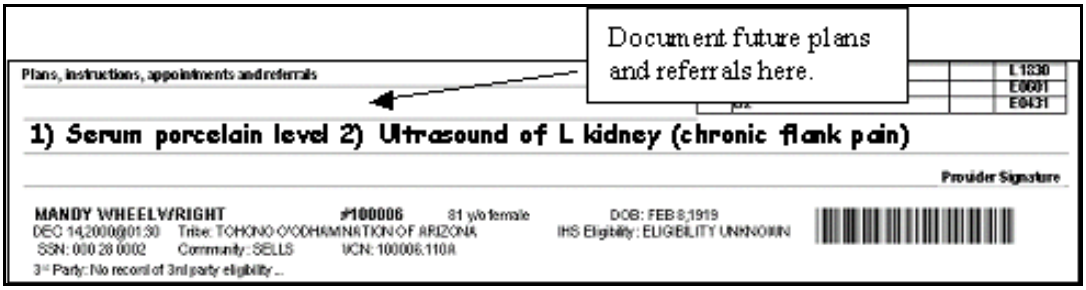


Figure 5-32: Entering Future Scheduled Encounters and Referrals Here

5.7.3 Patient Instructions

The old PCC encounter form had a perforated strip on the bottom copy that could be handed to the patient. The new form has no copies, so no tear-off strip is possible. Instead, a separate page is printed that can be filled out and given to the patient. It includes patient identifiers, a work/school excuse, and plenty of room for written instructions. If the page is not needed, shred it.

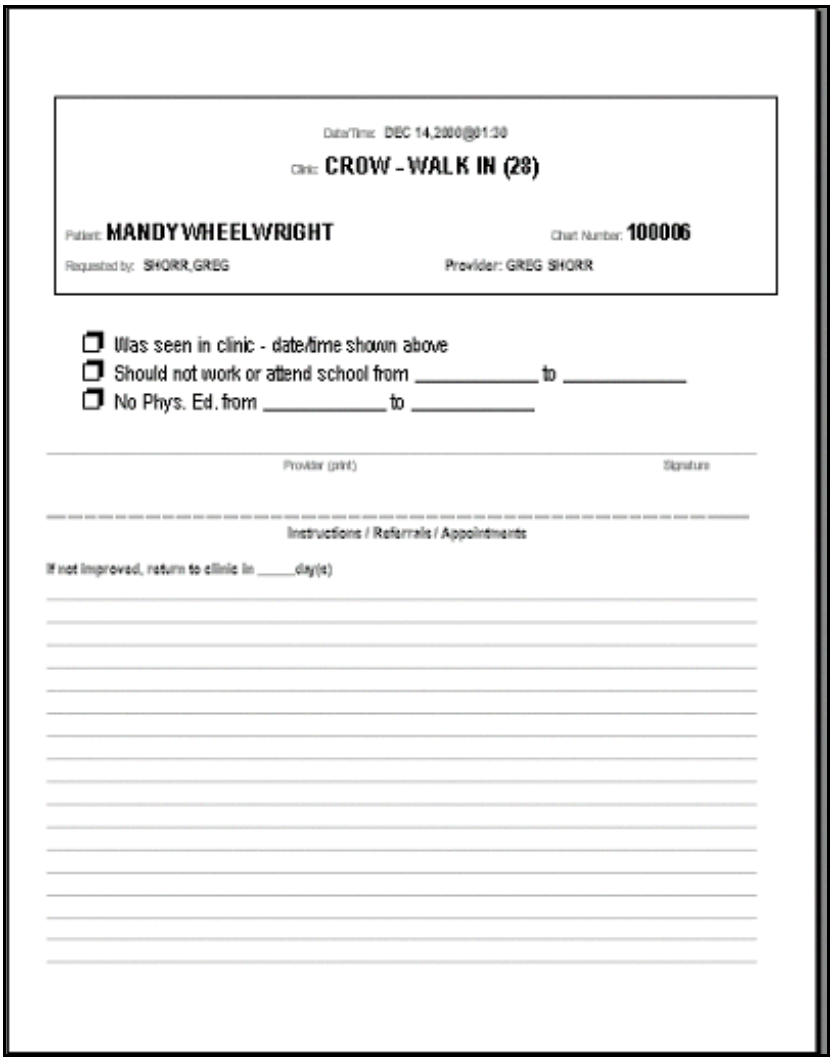


Figure 5-33: Patient Instructions Sheet

6.0 Appendix A: Sample Forms

CHART REQUEST

Date/Time: **«timestamp»**

Clinic: **«hdr»**

Patient: **«patient»** Chart Number: **«chart»**

Requested by: **«reqd»PETER** **«provider»E**

NUMBER OF ROUTING	LOCATION	PRIORITY	TIME

Date/Time: **JAN 22,2001@10:04**

Clinic: **CROW - WALK IN (28)**

Patient: **RAE WATERMAN** Chart Number: **100003**

Requested by: **SMITH,JANE** **Provider: PETER SCHORE**

☐ Was seen in clinic - date/time shown above

☐ Should not work or attend school from _____ to _____

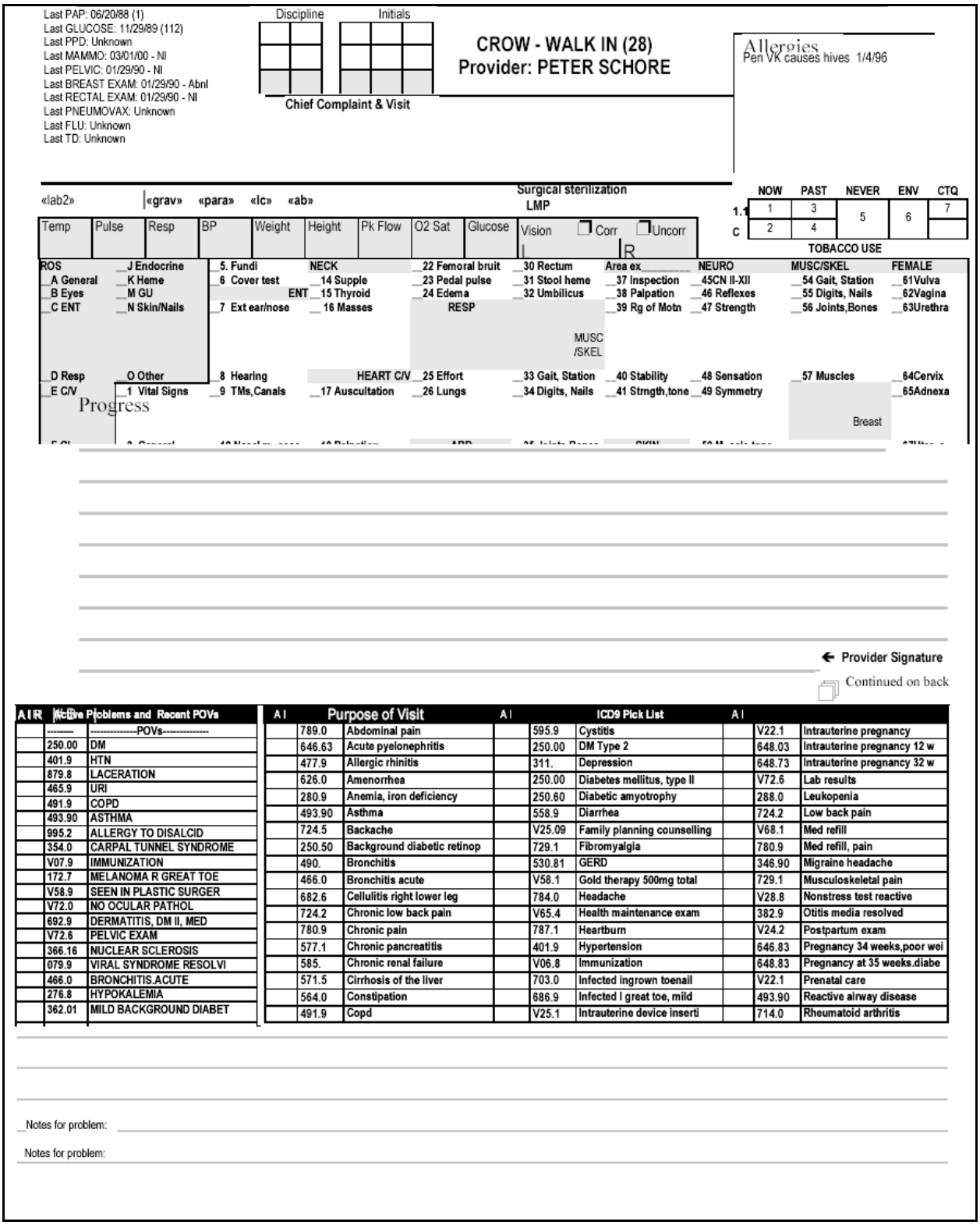
☐ No Phys. Ed. from _____ to _____

_____ _____

Provider (print) Signature

Instructions / Referrals / Appointments

If not improved, return to clinic in _____day(s)



Last PAP: 06/20/88 (1)
Last GLUCOSE: 11/29/89 (112)
Last PPD: Unknown
Last MAMMO: 03/01/00 - Nl
Last PELVIC: 01/29/90 - Nl
Last BREAST EXAM: 01/29/90 - Abnl
Last RECTAL EXAM: 01/29/90 - Nl
Last PNEUMOVAX: Unknown
Last FLU: Unknown
Last TD: Unknown

Discipline | Initials

Chief Complaint & Visit

CROW - WALK IN (28)
Provider: PETER SCHORE

Allergies
Pen VK causes hives 1/4/96

«lab2» «grav» «para» «lc» «ab»

Surgical sterilization
LMP

	NOW	PAST	NEVER	ENV	CTQ
1.1	1	3	5	6	7
C	2	4			

TOBACCO USE

Temp	Pulse	Resp	BP	Weight	Height	Pk Flow	O2 Sat	Glucose	Vision ☐ Corr ☐ Uncorr L R

ROS												
_A General	_J Endocrine	_5. Fundi	NECK	_22 Femoral bruit	_30 Rectum	Area ex_____	NEURO	MUSC/SKEL	FEMALE
_B Eyes	_M GU	_6 Cover test	ENT _14 Supple	_23 Pedal pulse	_31 Stool heme	_37 Inspection	_45CN II-XII	_54 Gait, Station	_61Vulva
_C ENT	_N Skin/Nails	_7 Ext ear/nose	_15 Thyroid	_24 Edema	_32 Umbilicus	_38 Palpation	_46 Reflexes	_55 Digits, Nails	_62Vagina
			_16 Masses	RESP		_39 Rg of Motn	_47 Strength	_56 Joints,Bones	_63Urethra
_D Resp	_O Other	_8 Hearing	HEART C/V	_25 Effort	_33 Gait, Station	_40 Stability	_48 Sensation	_57 Muscles	_64Cervix
_E C/V	_1 Vital Signs	_9 TMs,Canals	_17 Auscultation	_26 Lungs	_34 Digits, Nails	_41 Strngth,tone	_49 Symmetry	Breast	_65Adnexa

Progress

← Provider Signature

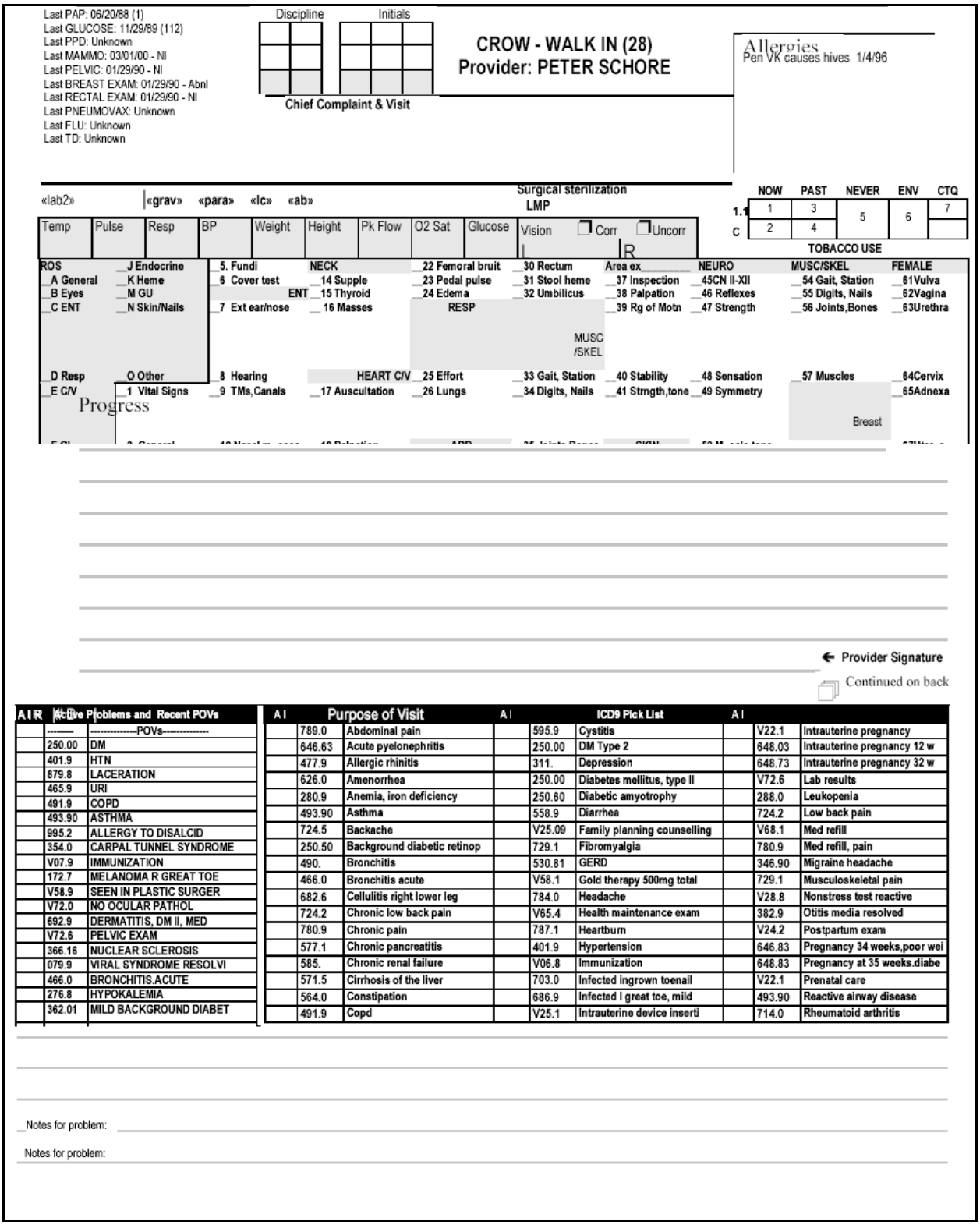
Continued on back

A I R	Active Problems and Recent POVs	
	-------	----------POVs----------
	250.00	DM
	401.9	HTN
	879.8	LACERATION
	465.9	URI
	491.9	COPD
	493.90	ASTHMA
	995.2	ALLERGY TO DISALCID
	354.0	CARPAL TUNNEL SYNDROME
	V07.9	IMMUNIZATION
	172.7	MELANOMA R GREAT TOE
	V58.9	SEEN IN PLASTIC SURGER
	V72.0	NO OCULAR PATHOL
	692.9	DERMATITIS, DM II, MED
	V72.6	PELVIC EXAM
	366.16	NUCLEAR SCLEROSIS
	079.9	VIRAL SYNDROME RESOLVI
	466.0	BRONCHITIS.ACUTE
	276.8	HYPOKALEMIA
	362.01	MILD BACKGROUND DIABET

A I	Purpose of Visit		A I	ICD9 Pick List		A I	
	789.0	Abdominal pain		595.9	Cystitis		V22.1	Intrauterine pregnancy
	646.63	Acute pyelonephritis		250.00	DM Type 2		648.03	Intrauterine pregnancy 12 w
	477.9	Allergic rhinitis		311.	Depression		648.73	Intrauterine pregnancy 32 w
	626.0	Amenorrhea		250.00	Diabetes mellitus, type II		V72.6	Lab results
	280.9	Anemia, iron deficiency		250.60	Diabetic amyotrophy		288.0	Leukopenia
	493.90	Asthma		558.9	Diarrhea		724.2	Low back pain
	724.5	Backache		V25.09	Family planning counselling		V68.1	Med refill
	250.50	Background diabetic retinop		729.1	Fibromyalgia		780.9	Med refill, pain
	490.	Bronchitis		530.81	GERD		346.90	Migraine headache
	466.0	Bronchitis acute		V58.1	Gold therapy 500mg total		729.1	Musculoskeletal pain
	682.6	Cellulitis right lower leg		784.0	Headache		V28.8	Nonstress test reactive
	724.2	Chronic low back pain		V65.4	Health maintenance exam		382.9	Otitis media resolved
	780.9	Chronic pain		787.1	Heartburn		V24.2	Postpartum exam
	577.1	Chronic pancreatitis		401.9	Hypertension		646.83	Pregnancy 34 weeks,poor wei
	585.	Chronic renal failure		V06.8	Immunization		648.83	Pregnancy at 35 weeks.diabe
	571.5	Cirrhosis of the liver		703.0	Infected ingrown toenail		V22.1	Prenatal care
	564.0	Constipation		686.9	Infected l great toe, mild		493.90	Reactive airway disease
	491.9	Copd		V25.1	Intrauterine device inserti		714.0	Rheumatoid arthritis

_Notes for problem:

Notes for problem:



Last PAP: 06/20/88 (1)
Last GLUCOSE: 11/29/89 (112)
Last PPD: Unknown
Last MAMMO: 03/01/00 - Nl
Last PELVIC: 01/29/90 - Nl
Last BREAST EXAM: 01/29/90 - Abnl
Last RECTAL EXAM: 01/29/90 - Nl
Last PNEUMOVAX: Unknown
Last FLU: Unknown
Last TD: Unknown

Discipline | Initials

Chief Complaint & Visit

CROW - WALK IN (28)
Provider: PETER SCHORE

Allergies
Pen VK causes hives 1/4/96

«lab2» «grav» «para» «lc» «ab»

Surgical sterilization
LMP

	NOW	PAST	NEVER	ENV	CTQ
1.1	1	3	5	6	7
C	2	4			

TOBACCO USE

Temp	Pulse	Resp	BP	Weight	Height	Pk Flow	O2 Sat	Glucose	Vision ☐ Corr ☐ Uncorr L R

ROS												
_A General	_J Endocrine	_5. Fundi	NECK	_22 Femoral bruit	_30 Rectum	Area ex_____	NEURO	MUSC/SKEL	FEMALE
_B Eyes	_K Heme	_6 Cover test	_14 Supple	_23 Pedal pulse	_31 Stool heme	_37 Inspection	_45CN II-XII	_54 Gait, Station	_61Vulva
_C ENT	_M GU	ENT _7 Ext ear/nose	_15 Thyroid	_24 Edema	_32 Umbilicus	_38 Palpation	_46 Reflexes	_55 Digits, Nails	_62Vagina
	_N Skin/Nails		_16 Masses	RESP		_39 Rg of Motn	_47 Strength	_56 Joints,Bones	_63Urethra
_D Resp	_O Other	_8 Hearing	HEART C/V	_25 Effort	_33 Gait, Station	_40 Stability	_48 Sensation	_57 Muscles	_64Cervix
_E C/V	_1 Vital Signs	_9 TMs,Canals	_17 Auscultation	_26 Lungs	_34 Digits, Nails	_41 Strngth,tone	_49 Symmetry	Breast	_65Adnexa

Progress

← Provider Signature

Continued on back

A I R	Active Problems and Recent POVs	
	--------	----------POVs----------
	250.00	DM
	401.9	HTN
	879.8	LACERATION
	465.9	URI
	491.9	COPD
	493.90	ASTHMA
	995.2	ALLERGY TO DISALCID
	354.0	CARPAL TUNNEL SYNDROME
	V07.9	IMMUNIZATION
	172.7	MELANOMA R GREAT TOE
	V58.9	SEEN IN PLASTIC SURGER
	V72.0	NO OCULAR PATHOL
	692.9	DERMATITIS, DM II, MED
	V72.6	PELVIC EXAM
	366.16	NUCLEAR SCLEROSIS
	079.9	VIRAL SYNDROME RESOLVI
	466.0	BRONCHITIS.ACUTE
	276.8	HYPOKALEMIA
	362.01	MILD BACKGROUND DIABET

A I	Purpose of Visit		A I	ICD9 Pick List		A I	
	789.0	Abdominal pain		595.9	Cystitis		V22.1	Intrauterine pregnancy
	646.63	Acute pyelonephritis		250.00	DM Type 2		648.03	Intrauterine pregnancy 12 w
	477.9	Allergic rhinitis		311.	Depression		648.73	Intrauterine pregnancy 32 w
	626.0	Amenorrhea		250.00	Diabetes mellitus, type II		V72.6	Lab results
	280.9	Anemia, iron deficiency		250.60	Diabetic amyotrophy		288.0	Leukopenia
	493.90	Asthma		558.9	Diarrhea		724.2	Low back pain
	724.5	Backache		V25.09	Family planning counselling		V68.1	Med refill
	250.50	Background diabetic retinop		729.1	Fibromyalgia		780.9	Med refill, pain
	490.	Bronchitis		530.81	GERD		346.90	Migraine headache
	466.0	Bronchitis acute		V58.1	Gold therapy 500mg total		729.1	Musculoskeletal pain
	682.6	Cellulitis right lower leg		784.0	Headache		V28.8	Nonstress test reactive
	724.2	Chronic low back pain		V65.4	Health maintenance exam		382.9	Otitis media resolved
	780.9	Chronic pain		787.1	Heartburn		V24.2	Postpartum exam
	577.1	Chronic pancreatitis		401.9	Hypertension		646.83	Pregnancy 34 weeks,poor wei
	585.	Chronic renal failure		V06.8	Immunization		648.83	Pregnancy at 35 weeks.diabe
	571.5	Cirrhosis of the liver		703.0	Infected ingrown toenail		V22.1	Prenatal care
	564.0	Constipation		686.9	Infected l great toe, mild		493.90	Reactive airway disease
	491.9	Copd		V25.1	Intrauterine device inserti		714.0	Rheumatoid arthritis

_Notes for problem:

Notes for problem:

RSBCIHI Dental Encounter Record

Dental 50-002 (Revised 1/00)

Notes

--------	----------POVs----------
250.00	DM
401.9	HTN
879.8	LACERATION
465.9	URI
491.9	COPD
493.90	ASTHMA
995.2	ALLERGY TO DISALCID
354.0	CARPAL TUNNEL SYNDROME
V07.9	IMMUNIZATION
172.7	MELANOMA R GREAT TOE
V58.9	SEEN IN PLASTIC SURGER
V72.0	NO OCULAR PATHOL
692.9	DERMATITIS, DM II, MED
V72.6	PELVIC EXAM
366.16	NUCLEAR SCLEROSIS
079.9	VIRAL SYNDROME RESOLVI
466.0	BRONCHITIS,ACUTE
276.8	HYPOKALEMIA
362.01	MILD BACKGROUND DIABET

AL |# D |

Purpose of Visit

	1351	5025	Topical/Sealants per Tooth		4930		Emergency Treatment				
	1330	5024	Oral Hygiene Instructions		4341	5095	Subgingival Curettage				FIXED PROSTHETICS
	9110	5196	Emergency Treatment (palliative)				Root Planning per Quad		2751	5057	Porcelain with Metal
					4330		Correction of Occlusion per Quad		2790	5060	Gold
									2950	5070	Crown Buildup, Pin Retained
			ROENTGENOLOGY & PATHOLOGY						2930	5066	SSC Primary Tooth
	0220	5005	Single Film				ENDODONTICS		2920	5056	Re-cement Crown
	0230	5006	Additional Films (up to 12)		3110	5078	Pulp Capping Direct		6930	5160	Re-cement Bridge
	0210	5004	Full Mouth Series		3220	5080	Vital Pulpotomy		2750	5056	Porcelain Baked to Gold
	0240	5007	Intra-oral Occulsal View (maxil. or mandib. ea.)		3120	5079	Pulp Capping Indirect		6751	5154	Porcelain with Metal Abutment
	0272	5010	Bite Wing Films (2)		3310	5083	Single Rooted Tooth		6241	5145	Porcelain with Metal Pontic
	0274	5011	Bite Winf Films (4)		3320	5084	Bi-rooted Tooth				
	0330	5013	Panorex Film (only)		3330	5085	Three Canals				
					3340	5086	Four Canals				REMOVABLE PROSTHETICS
									5110	5101	Complete Maxillary Denture
			ORAL SURGERY						5120	5102	Complete Mandibular Denture
	7110	5164	Uncomplicated				RESTORATIVE DENTISTRY, PRIMARY		5310	5111	Teeth and Clasps
	7120		Each Additional Tooth		2110	5031	One Tooth Surface				Extra / Unit
	7210	5169	Surgical Removal - Post OP Visit Complication:		2120	5032	Two Tooth Surfaces		5820	5135	Stayplate-base Free
	7220	5170	Soft Tissue		2130	5034	Three or More Tooth Surfaces		5822		Teeth and Clasp
	7230	5171	Partially Boney								Extra / Unit
	7240	5172	Complete Boney						5400	5112	Denture Adjustments
	7270	5174	Reimplant/Stabilize Teeth (post accident)				SPACE MAINTENANCE		5750	5131	Denture Reline
					1510	5026	Fixed Space Maintenance		5600	5230	Broken denture Repair

New Prescriptions

Revisit / Referral To: Instructions:

Purpose

Provider Signature

«patient» «agesex» DOB: «dob» «ssn» «tribe»«community»

#«chart» «timestamp» «provider» Eligibility: «elig» VCN: «uid»

RSBCIHI Optical Department Encounter Record

Optical 40-004 (Revised 1/00)

Notes

A I	# D	Purpose of Visit	466.0

											362.81 Hemorrhage
	374.10 Ectropion		370.90 Keratitis		378.10 Exotropia		379.31 Aphakia R L				362.10 Hypertensive Retinopathy
	373.11 Hordeolum Externum		375.15 Keratitis Sicca		368.30 Fusion Dysfunction		366.90 Cataract				362.50 Macular Degeneration
	373.12 Hordeolum Internum		371.60 Keratoconus		378.43 Hyperphoria		366.16 Sclerosis				224.60 Nevus
	374.30 Ptosis		370.60 Neurovascular		378.31 Hypertropia						362.60 Retinal Degeneration
	374.05 Trichisis		371.13 Pigmentation		379.50 Nystagmus		**VITREOUS**				362.74 Retinal Pigment
	078.10 Verruca				378.55 Paresis		379.21 Vitreous Degeneration				363.30 Scar
	374.51 Xanthelasma		**FUNCTIONAL**		368.13 Photophobia		397.23 Vitreous Hemorrhage				363.31 Solar Retinitis
			367.55 Accom. Dysfunction		378.90 Occulomotor Dysfunction						
	CONJUNCTIVA / SCLERA		388.00 Amblyopia		368.31 Supression		**REFRACTIVE**				**GENERAL (by Hx)**
	372.14 Allergies		379.41 Anisocoria		315.50 Visualization Dysfunction		367.32 Aniseikonia				250.50 Diabetes
	379.00 Episcleritis		367.31 Anisometropia		780.70 Visual Fatigue		367.00 Hyperopia				784.00 Headache
	930.00 Foreign Body		368.30 Binocular Dysfunction		368.13 Visual Discomfort		367.20 Astigmatism				401.90 Hypertension
	372.03 Infections		388.40 Blindness		368.40 Visual Field Defect						315.20 Learning Disability
	372.51 Pinguecula		368.8 Blurred Vision		315.90 Visual Motor Dysfunction		367.10 Myopia				346.00 Migraine
	372.40 Pterigium		368.59 Color Vision Deficiency				367.40 Presbyopia				240.00 Thyroid
	372.72 Subconj. Hemorrhage		378.84 Converg. Excess								

Treatments and CPT Codes

	NEW PATIENT		OTHER SERVICES		CONTACT LENS SERVICES		APHAKIA		SPECIAL CONTACTS
	90000 Brief Exam		99050 After Hours Visit		92311 Aphakic Fitting		92353 Bifocal		A4520 Bandage
	92004 Comprehensive Exam		90610 Consultation		92335 Cosmetic Fitting		92352 Monofocal		V2512 HGP Bifocal
	90010 Limited Exam		92499 Home Visit		92310 Evaluation, Initial		92371 Repair/Refit		V2513 HGP Extended Wear
	92002 Intermediate Exam		99070 Materials / Supplies		92324 Evaluation, Refit		92358 Temporary w/Mat		V6457 HGP Replacement

☐ Disabled Onset_____

☐ Partially Disabled Est. End_____

☐ Never Disabled Actual End_____

OK To Work: YES NO

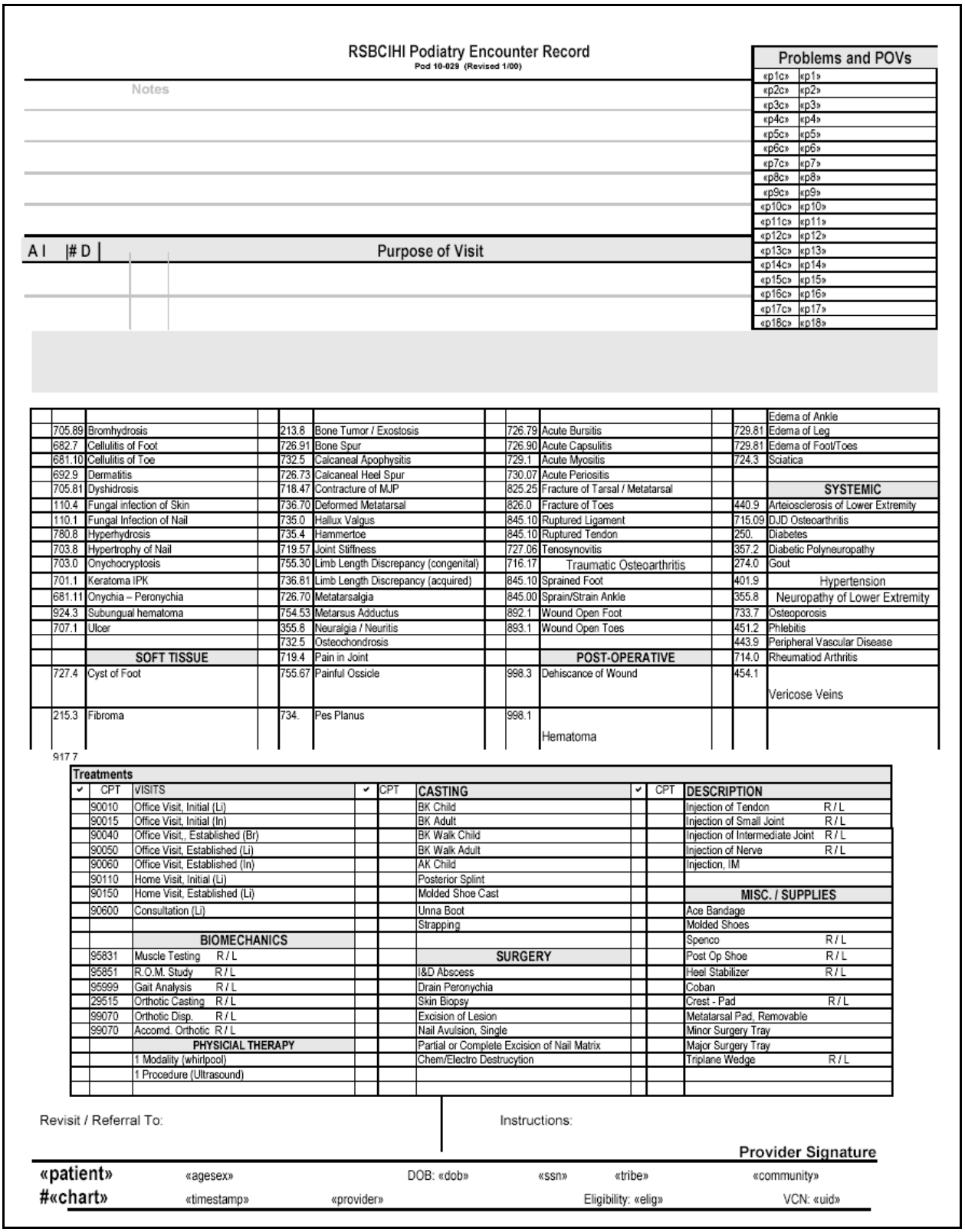
Revisit / Referral To: Instructions:

Purpose:

Provider Signature

«patient» «agesex» DOB: «dob» «ssn» «tribe» «community»

#«chart» «timestamp» «provider» Eligibility: «elig» VCN: «uid»



RSBCIHI Podiatry Encounter Record
Pod 10-029 (Revised 1/00)

Notes

Problems and POVs	
«p1c»	«p1»
«p2c»	«p2»
«p3c»	«p3»
«p4c»	«p4»
«p5c»	«p5»
«p6c»	«p6»
«p7c»	«p7»
«p8c»	«p8»
«p9c»	«p9»
«p10c»	«p10»
«p11c»	«p11»
«p12c»	«p12»
«p13c»	«p13»
«p14c»	«p14»
«p15c»	«p15»
«p16c»	«p16»
«p17c»	«p17»
«p18c»	«p18»

A I | # D | Purpose of Visit

											Edema of Ankle
	705.89	Bromhydrosis		213.8	Bone Tumor / Exostosis		726.79	Acute Bursitis		729.81	Edema of Leg
	682.7	Cellulitis of Foot		726.91	Bone Spur		726.90	Acute Capsulitis		729.81	Edema of Foot/Toes
	681.10	Cellulitis of Toe		732.5	Calcaneal Apophysitis		729.1	Acute Myositis		724.3	Sciatica
	692.9	Dermatitis		726.73	Calcaneal Heel Spur		730.07	Acute Pericisitis			
	705.81	Dyshidrosis		718.47	Contracture of MJP		825.25	Fracture of Tarsal / Metatarsal			**SYSTEMIC**
	110.4	Fungal infection of Skin		736.70	Deformed Metatarsal		826.0	Fracture of Toes		440.9	Arteiosclerosis of Lower Extremity
	110.1	Fungal Infection of Nail		735.0	Hallux Valgus		845.10	Ruptured Ligament		715.09	DJD Osteoarthritis
	780.8	Hyperhydrosis		735.4	Hammertoe		845.10	Ruptured Tendon		250.	Diabetes
	703.8	Hypertrophy of Nail		719.57	Joint Stiffness		727.06	Tenosynovitis		357.2	Diabetic Polyneuropathy
	703.0	Onychocryptosis		755.30	Limb Length Discrepancy (congenital)		716.17	Traumatic Osteoarthritis		274.0	Gout
	701.1	Keratoma IPK		736.81	Limb Length Discrepancy (acquired)		845.10	Sprained Foot		401.9	Hypertension
	681.11	Onychia – Peronychia		726.70	Metatarsalgia		845.00	Sprain/Strain Ankle		355.8	Neuropathy of Lower Extremity
	924.3	Subungual hematoma		754.53	Metarsus Adductus		892.1	Wound Open Foot		733.7	Osteoporosis
	707.1	Ulcer		355.8	Neuralgia / Neuritis		893.1	Wound Open Toes		451.2	Phlebitis
				732.5	Osteochondrosis					443.9	Peripheral Vascular Disease
		SOFT TISSUE		719.4	Pain in Joint			**POST-OPERATIVE**		714.0	Rheumatiod Arthritis
	727.4	Cyst of Foot		755.67	Painful Ossicle		998.3	Dehiscance of Wound		454.1	Vericose Veins
	215.3	Fibroma		734.	Pes Planus		998.1	Hematoma			

917.7

Treatments

✔	CPT	VISITS	✔	CPT	CASTING	✔	CPT	DESCRIPTION
	90010	Office Visit, Initial (Li)			BK Child			Injection of Tendon R / L
	90015	Office Visit, Initial (In)			BK Adult			Injection of Small Joint R / L
	90040	Office Visit,, Established (Br)			BK Walk Child			Injection of Intermediate Joint R / L
	90050	Office Visit, Established (Li)			BK Walk Adult			Injection of Nerve R / L
	90060	Office Visit, Established (In)			AK Child			Injection, IM
	90110	Home Visit, Initial (Li)			Posterior Splint			
	90150	Home Visit, Established (Li)			Molded Shoe Cast			**MISC. / SUPPLIES**
	90600	Consultation (Li)			Unna Boot			Ace Bandage
					Strapping			Molded Shoes
		BIOMECHANICS						Spenco R / L
	95831	Muscle Testing R / L			**SURGERY**			Post Op Shoe R / L
	95851	R.O.M. Study R / L			I&D Abscess			Heel Stabilizer R / L
	95999	Gait Analysis R / L			Drain Peronychia			Coban
	29515	Orthotic Casting R / L			Skin Biopsy			Crest - Pad R / L
	99070	Orthotic Disp. R / L			Excision of Lesion			Metatarsal Pad, Removable
	99070	Accomd. Orthotic R / L			Nail Avulsion, Single			Minor Surgery Tray
		PHYSICIAL THERAPY			Partial or Complete Excision of Nail Matrix			Major Surgery Tray
		1 Modality (whirlpool)			Chem/Electro Destrucytion			Triplane Wedge R / L
		1 Procedure (Ultrasound)						

Revisit / Referral To:

Instructions:

Provider Signature

«patient» «agesex» DOB: «dob» «ssn» «tribe» «community»

#«chart» «timestamp» «provider» Eligibility: «elig» VCN: «uid»

RSBCIHI Behavioral Health Encounter Record

BHS 80-008 (Revised 1/00

Notes

A I | # D | Purpose of Visit

DIAGNOSES

✔	CODE	CHILDHOOD ADOLESCENT DIS.	✔	CODE	COGNITIVE DISORDERS	✔	CODE	SOMATOFORM DISORDERS	✔	CODE	PERSONALITY DISORDERS
	1201	317.00 Mild Mental Retard.		1206	780.09 Delirium, NOS		1146	300.81 Somatization Disorder		1170	Paranoid Personality Disorder
	1202	318.00 Moderate Mental Retard.		1106	294.80 Dementia, NOS		1148	300.11Conversion Disorder		1171	Schizoid Personality Disorder
	1203	318.10 Severe Mental Retard.		1207	294.80 Cognitive Disorder, NOS			307. Pain Disorder		1172	Schizotypal Personality Dis.
	1117	314.00 Attention Deficit/Hyper.					1220	300.81 Somatoform Disorder		1175	Antisocial Personality Dis.
	1204	314.90 Attn Deficit/Hyper NOS			PSYCHOTIC DISORDERS					1176	Borderline Personality Dis.
	1118	312.80Conduct Disorder			295. Schizophrenia			DISSOCIATIVE DISORDERS		1173	Histrionic Personality Dis.
	1122	313.81 Oppositional Defiant Dis.		1127	295.40 Schizophreniform Disorder		0596	300.60 Depersonalization Disorder		1174	Narcissistic Personality Dis.
	1205	312.90 Disruptive Behavior Dis., NOS		1126	297.10 Delusional Disorder		1160	300.14 Dissociative Identity Disorder		1177	Avoidant Personality Dis.
	1119	309.21 Separation Anxiety Dis.		1128	298.90 Psychotic Disorder, NOS		1221	300.15 Dissociative Disorder, NOS		1178	Dependent Personality Dis.
	1120	313.90 Disorder of Childhood, NOS		1128	298.90 Psychotic Disorder, NOS					1179	Obsessive-Compulsive Dis.
								IMPULSE CONTROL DISORDERS		1181	Personality Disorder, NOS
					MOOD DISORDERS		1152				
	1107	305.00 Alcohol Abuse		0478	311.00 Depressive Disorder, NOS		1158	312.31 Pathological Gambling		1151	Bulimia Nervosia
	1112	304.40 Amphetamine Dependence			296. Bipolar I Disorder		1222	312.39 Trychotillomania		1154	Eating Disorder, NOS
	1111	305.70 AMPHETAMINE		1215	296.89 Bipolar II Disorder		1223	312.30 Impulse Control Disorder, NOS			
	1208	304.30 Cannabis Dependence		1216	310.13 Cyclothymic Disorder						ADJUSTMENT DISORDERS
	1114	305.2 Cannabis Abuse		1217	296.80 Bipolar Disorder, NOS			OTHER CONDITIONS		1162	Adj. Dis. w/ Depressed Mood
	1209	304.20 Cocaine Dependence		1218	293.83 Mood Disorder due to....		1224	333.90 Med Induced Mvmt Dis., NOS		1163	Adj. Dis. w/Anxiety
	1110	305.60 Cocaine Abuse		1219	296.90 Mood Disorder, NOS		0443	995.20 Adverse Effects of Med, NOS		1164	Adj. Dis. w/ Mixed Emotions
	1210	304.50 Hallucinogenic Dependence					1192	V61.20 Parent-Child Relational Prob.		1165	Adj. Dis. w/ Conduct Disturbance
	1115	305.30 Hallucinogenic Abuse			ANXIETY DISORDERS		1191	V61.10A Partner Relational Problem		1166	Adj. Dis. w/Emotions & Conduct
	1211	304.60 Inhalant Dependence		1141	300.01 Panic Dis. w/o Agoraphobia		1183	V62.81 Relational Problem, NOS		1169	Adj. Dis., NOS
	1113	305.90 Inhalant Abuse		1137	300.21 Panic Dis. w/ Agoraphobia		1195	V62.21 Abuse/Neglect of Child			

	99348										

Revisit / Referral To: Instructions:

Provider Signature

«patient» «agesex» DOB: «dob» «ssn» «tribe» «community»

#«chart» «timestamp» «provider» Eligibility: «elig» VCN: «uid»

RSBCIHI Brief Encounter Record

Med 10-027 (Revised 1/00)

Subjective/Objective

☐ Walk-in
☐ Phone

A I R	Active Problems ----- Recent POVs		A I		A I	ICD9 Pick List	A I		
	--------	----------POVs----------	789.0	Abdominal pain	311.	Depression	288.0	Leukopenia	
	250.00	DM	646.63	Acute pyelonephritis	250.00	Diabetes mellitus, type II	724.2	Low back pain	
	401.9	HTN	477.9	Allergic rhinitis	250.60	Diabetic amyotrophy	V68.1	Med refill	
	879.8	LACERATION	626.0	Amenorrhea	558.9	Diarrhea	780.9	Med refill, pain	
	465.9	URI	280.9	Anemia, iron deficiency	V25.09	Family planning counselling	346.90	Migraine headache	
	491.9	COPD	493.90	Asthma	729.1	Fibromyalgia	729.1	Musculoskeletal pain	
	493.90	ASTHMA	724.5	Backache	530.81	GERD	V28.8	Nonstress test reactive	
	995.2	ALLERGY TO DISALCID	250.50	Background diabetic retinop	V58.1	Gold therapy 500mg total	382.9	Otitis media resolved	
	354.0	CARPAL TUNNEL SYNDROME	490.	Bronchitis	784.0	Headache	V24.2	Postpartum exam	
	V07.9	IMMUNIZATION	466.0	Bronchitis acute	V65.4	Health maintenance exam	646.83	Pregnancy 34 weeks,poor wei	
	172.7	MELANOMA R GREAT TOE	682.6	Cellulitis right lower leg	787.1	Heartburn	648.83	Pregnancy at 35 weeks,diabe	
	V58.9	SEEN IN PLASTIC SURGER	724.2	Chronic low back pain	401.9	Hypertension	V22.1	Prenatal care	
	V72.0	NO OCULAR PATHOL	780.9	Chronic pain	V06.8	Immunization	493.90	Reactive airway disease	
	692.9	DERMATITIS, DM II, MED	577.1	Chronic pancreatitis	703.0	Infected ingrown toenail	714.0	Rheumatoid arthritis	
	V72.6	PELVIC EXAM	585.	Chronic renal failure	686.9	Infected I great toe, mild	V72.7	Skin testing	
	366.16	NUCLEAR SCLEROSIS	571.5	Cirrhosis of the liver	V25.1	Intrauterine device inserti	307.81	Tension headaches	
	079.9	VIRAL SYNDROME RESOLVI	564.0	Constipation	V22.1	Intrauterine pregnancy	V68.89	Third party resources	
	466.0	BRONCHITIS ACUTE	491.9	Copd	648.03	Intrauterine pregnancy 12 w	110.4	Tinea pedis	
	276.8	HYPOKALEMIA	595.9	Cystitis	648.73	Intrauterine pregnancy 32 w	795.5	Tuberculosis, ppd reactor,	

A I R | # D | **Purpose of Visit**

Prescriptions and Orders	Signature and Date	Refills
01/16/01 (C) LISINOPRIL 10MG TABS #30 (30 days) Take 1 QAM		
01/11/01 KETACONAZOLE 200MG TAB #6 (3 days) Take 1 BID -- Ran out 01/14/01		

Revisit/Purpose:

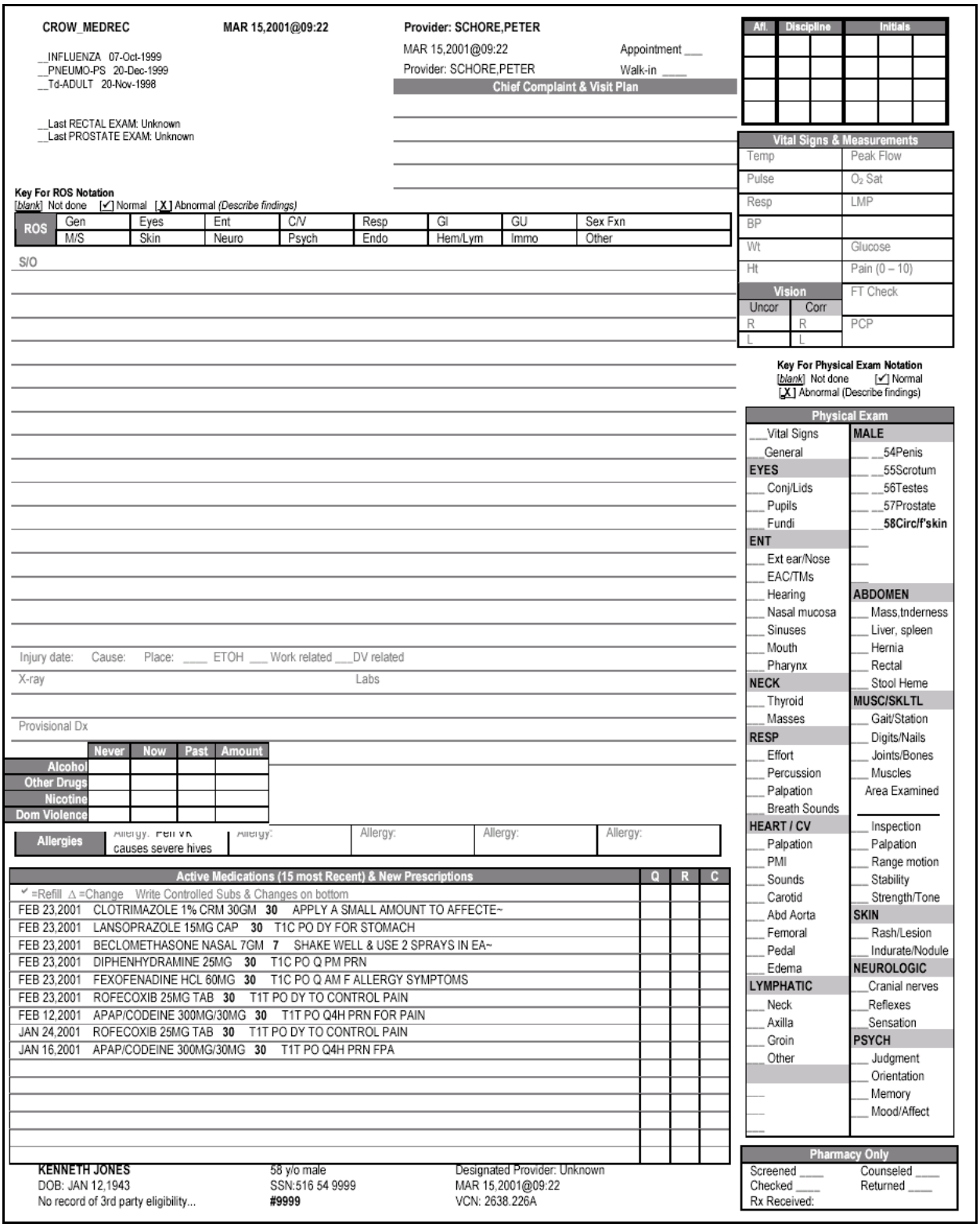
Referral/Purpose:

Instructions:

Provider Signature

«patient» «agesex» DOB: «dob» «ssn» «tribe»«community»

#**«chart»** «timestamp» «provider»PETER SCHORE Eligibility: «elig» VCN: «uid»



CROW_MEDREC MAR 15,2001@09:22 Provider: SCHORE,PETER

MAR 15,2001@09:22 Appointment ___
Provider: SCHORE,PETER Walk-in ____

__INFLUENZA 07-Oct-1999
__PNEUMO-PS 20-Dec-1999
__Td-ADULT 20-Nov-1998

__Last RECTAL EXAM: Unknown
__Last PROSTATE EXAM: Unknown

Chief Complaint & Visit Plan

Afl.	Discipline		Initials		

Vital Signs & Measurements

Temp	Peak Flow
Pulse	O_2 Sat
Resp	LMP
BP	
Wt	Glucose
Ht	Pain (0 – 10)
Vision	FT Check
Uncor / Corr	
R / R	PCP
L / L	

Key For ROS Notation
[blank] Not done [✓] Normal [X] Abnormal (Describe findings)

ROS								
	Gen	Eyes	Ent	C/V	Resp	GI	GU	Sex Fxn
	M/S	Skin	Neuro	Psych	Endo	Hem/Lym	Immo	Other

S/O

Injury date: Cause: Place: ____ ETOH ___ Work related ___DV related

X-ray Labs

Provisional Dx

	Never	Now	Past	Amount
Alcohol				
Other Drugs				
Nicotine				
Dom Violence				

Allergies	Allergy: Pen VK causes severe hives	Allergy:	Allergy:	Allergy:	Allergy:

Key For Physical Exam Notation
[blank] Not done [✓] Normal
[X] Abnormal (Describe findings)

Physical Exam

___Vital Signs	**MALE**
___General	___ __54Penis
EYES	___ __55Scrotum
___ Conj/Lids	___ __56Testes
___ Pupils	___ __57Prostate
___ Fundi	___ __**58Circ/f'skin**
ENT	___
___ Ext ear/Nose	___
___ EAC/TMs	___
___ Hearing	**ABDOMEN**
___ Nasal mucosa	___ Mass,tnderness
___ Sinuses	___ Liver, spleen
___ Mouth	___ Hernia
___ Pharynx	___ Rectal
NECK	___ Stool Heme
___ Thyroid	**MUSC/SKLTL**
___ Masses	___ Gait/Station
RESP	___ Digits/Nails
___ Effort	___ Joints/Bones
___ Percussion	___ Muscles
___ Palpation	Area Examined
___ Breath Sounds	_____
HEART / CV	___ Inspection
___ Palpation	___ Palpation
___ PMI	___ Range motion
___ Sounds	___ Stability
___ Carotid	___ Strength/Tone
___ Abd Aorta	**SKIN**
___ Femoral	___ Rash/Lesion
___ Pedal	___ Indurate/Nodule
___ Edema	**NEUROLOGIC**
LYMPHATIC	___Cranial nerves
___ Neck	___Reflexes
___ Axilla	___Sensation
___ Groin	**PSYCH**
___ Other	___ Judgment
	___ Orientation
___	___ Memory
___	___ Mood/Affect
___	

Active Medications (15 most Recent) & New Prescriptions		Q	R	C
✓=Refill △=Change Write Controlled Subs & Changes on bottom				
FEB 23,2001	CLOTRIMAZOLE 1% CRM 30GM **30** APPLY A SMALL AMOUNT TO AFFECTE~			
FEB 23,2001	LANSOPRAZOLE 15MG CAP **30** T1C PO DY FOR STOMACH			
FEB 23,2001	BECLOMETHASONE NASAL 7GM **7** SHAKE WELL & USE 2 SPRAYS IN EA~			
FEB 23,2001	DIPHENHYDRAMINE 25MG **30** T1C PO Q PM PRN			
FEB 23,2001	FEXOFENADINE HCL 60MG **30** T1C PO Q AM F ALLERGY SYMPTOMS			
FEB 23,2001	ROFECOXIB 25MG TAB **30** T1T PO DY TO CONTROL PAIN			
FEB 12,2001	APAP/CODEINE 300MG/30MG **30** T1T PO Q4H PRN FOR PAIN			
JAN 24,2001	ROFECOXIB 25MG TAB **30** T1T PO DY TO CONTROL PAIN			
JAN 16,2001	APAP/CODEINE 300MG/30MG **30** T1T PO Q4H PRN FPA			

Pharmacy Only
Screened ____ Counseled ____
Checked ____ Returned ____
Rx Received:

KENNETH JONES 58 y/o male Designated Provider: Unknown
DOB: JAN 12,1943 SSN:516 54 9999 MAR 15,2001@09:22
No record of 3rd party eligibility... **#9999** VCN: 2638.226A

CROW_MEDREC MAR 15,2001@09:22 Provider: SCHORE,PETER

__INFLUENZA 07-Oct-1999
__PNEUMO-PS 20-Dec-1999
__Td-ADULT 20-Nov-1998

__Last RECTAL EXAM: Unknown
__Last PROSTATE EXAM: Unknown

MAR 15,2001@09:22 Appointment ___
Provider: SCHORE,PETER Walk-in ____

Chief Complaint & Visit Plan

Afl.	Discipline		Initials		

Vital Signs & Measurements

Temp	Peak Flow
Pulse	O_2 Sat
Resp	LMP
BP	
Wt	Glucose
Ht	Pain (0 – 10)
Vision	FT Check
Uncor / Corr	
R / R	PCP
L / L	

Key For ROS Notation
[*blank*] Not done [✓] Normal [X] Abnormal *(Describe findings)*

ROS	Gen	Eyes	Ent	C/V	Resp	GI	GU	Sex Fxn
	M/S	Skin	Neuro	Psych	Endo	Hem/Lym	Immo	Other

S/O

Injury date: Cause: Place: ____ ETOH ___ Work related ___DV related

X-ray Labs

Provisional Dx

	Never	Now	Past	Amount
Alcohol				
Other Drugs				
Nicotine				
Dom Violence				

Allergies	Allergy: Pen VK causes severe hives	Allergy:	Allergy:	Allergy:	Allergy:

Key For Physical Exam Notation
[*blank*] Not done [✓] Normal
[X] Abnormal (Describe findings)

Physical Exam

___Vital Signs	**MALE**
___General	___ __54Penis
EYES	___ __55Scrotum
___ Conj/Lids	___ __56Testes
___ Pupils	___ __57Prostate
___ Fundi	___ __**58Circ/f'skin**
ENT	___
___ Ext ear/Nose	___
___ EAC/TMs	___
___ Hearing	**ABDOMEN**
___ Nasal mucosa	___ Mass,tnderness
___ Sinuses	___ Liver, spleen
___ Mouth	___ Hernia
___ Pharynx	___ Rectal
NECK	___ Stool Heme
___ Thyroid	**MUSC/SKLTL**
___ Masses	___ Gait/Station
RESP	___ Digits/Nails
___ Effort	___ Joints/Bones
___ Percussion	___ Muscles
___ Palpation	Area Examined
___ Breath Sounds	_____
HEART / CV	___ Inspection
___ Palpation	___ Palpation
___ PMI	___ Range motion
___ Sounds	___ Stability
___ Carotid	___ Strength/Tone
___ Abd Aorta	**SKIN**
___ Femoral	___ Rash/Lesion
___ Pedal	___ Indurate/Nodule
___ Edema	**NEUROLOGIC**
LYMPHATIC	___Cranial nerves
___ Neck	___Reflexes
___ Axilla	___Sensation
___ Groin	**PSYCH**
___ Other	___ Judgment
	___ Orientation
___	___ Memory
___	___ Mood/Affect
___	

Active Medications (15 most Recent) & New Prescriptions		Q	R	C
✓ =Refill △ =Change Write Controlled Subs & Changes on bottom				
FEB 23,2001	CLOTRIMAZOLE 1% CRM 30GM **30** APPLY A SMALL AMOUNT TO AFFECTE~			
FEB 23,2001	LANSOPRAZOLE 15MG CAP **30** T1C PO DY FOR STOMACH			
FEB 23,2001	BECLOMETHASONE NASAL 7GM **7** SHAKE WELL & USE 2 SPRAYS IN EA~			
FEB 23,2001	DIPHENHYDRAMINE 25MG **30** T1C PO Q PM PRN			
FEB 23,2001	FEXOFENADINE HCL 60MG **30** T1C PO Q AM F ALLERGY SYMPTOMS			
FEB 23,2001	ROFECOXIB 25MG TAB **30** T1T PO DY TO CONTROL PAIN			
FEB 12,2001	APAP/CODEINE 300MG/30MG **30** T1T PO Q4H PRN FOR PAIN			
JAN 24,2001	ROFECOXIB 25MG TAB **30** T1T PO DY TO CONTROL PAIN			
JAN 16,2001	APAP/CODEINE 300MG/30MG **30** T1T PO Q4H PRN FPA			

KENNETH JONES 58 y/o male Designated Provider: Unknown
DOB: JAN 12,1943 SSN:516 54 9999 MAR 15,2001@09:22
No record of 3rd party eligibility... **#9999** VCN: 2638.226A

Pharmacy Only
Screened ____ Counseled ____
Checked ____ Returned ____
Rx Received:

CROW_MEDREC MAR 15,2001@09:22 Provider: SCHORE,PETER

__INFLUENZA 07-Oct-1999
__PNEUMO-PS 20-Dec-1999
__Td-ADULT 20-Nov-1998

__Last RECTAL EXAM: Unknown
__Last PROSTATE EXAM: Unknown

MAR 15,2001@09:22
Provider: SCHORE,PETER

Afl.	Discipline		Initials		

Chief Complaint & Visit Plan

Vital Signs & Measurements

Temp	
Pulse	
Resp	LMP
BP	
Wt	Glucose
Ht	Pain (0 – 10)

Vision		
Uncor	Corr	
R	R	PCP
L	L	

Key For ROS Notation
[*blank*] Not done [✓] Normal [X] Abnormal *(Describe findings)*

ROS	Gen	Eyes	Ent	C/V	Resp	GI	GU	Sex Fxn
	M/S	Skin	Neuro	Psych	Endo	Hem/Lym	Immo	Other

S/O

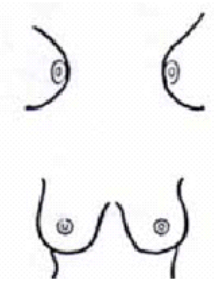
Family History:

Injury date: Cause: Place: ____ ETOH ___ Work related __DV related

X-ray/US Labs

Provisional Dx

	Never	Now	Past	Amount
Alcohol				
Other Drugs				
Nicotine				
Dom Violence				



Key For Physical Exam Notation
[*blank*] Not done [✓] Normal
[X] Abnormal (Describe findings)

Physical Exam

___Vital Signs	**MALE**
___General	__54Penis
EYES	__55Scrotum
___ Conj/Lids	__56Testes
___ Pupils	__57Prostate
___ Fundi	**__58Circ/f'skin**
ENT	
___ Ext ear/Nose	
___ EAC/TMs	
___ Hearing	**ABDOMEN**
___ Nasal mucosa	___ Mass,tnderness
___ Sinuses	___ Liver, spleen
___ Mouth	___ Hernia
___ Pharynx	___ Rectal
NECK	___ Stool Heme
___ Thyroid	**MUSC/SKLTL**
___ Masses	___ Gait/Station
RESP	___ Digits/Nails
___ Effort	___ Joints/Bones
___ Percussion	___ Muscles
___ Palpation	Area Examined
___ Breath Sounds	_____
HEART / CV	___ Inspection
___ Palpation	___ Palpation
___ PMI	___ Range motion
___ Sounds	___ Stability
___ Carotid	___ Strength/Tone
___ Abd Aorta	**SKIN**
___ Femoral	___ Rash/Lesion
___ Pedal	___ Indurate/Nodule
___ Edema	**NEUROLOGIC**
LYMPHATIC	___Cranial nerves
___ Neck	___Reflexes
___ Axilla	___Sensation
___ Groin	**PSYCH**
___ Other	___ Judgment
	___ Orientation
	___ Memory
	___ Mood/Affect
	Dental Screen

Allergies	Allergy: Pen VK causes severe hives	Allergy:	Allergy:	Allergy:	Allergy:

Active Medications (15 most Recent) & New Prescriptions	Q	R	C
✓ =Refill △ =Change Write Controlled Subs & Changes on bottom			
FEB 23,2001 CLOTRIMAZOLE 1% CRM 30GM **30** APPLY A SMALL AMOUNT TO AFFECTE~			
FEB 23,2001 LANSOPRAZOLE 15MG CAP **30** T1C PO DY FOR STOMACH			
FEB 23,2001 BECLOMETHASONE NASAL 7GM **7** SHAKE WELL & USE 2 SPRAYS IN EA~			
FEB 23,2001 DIPHENHYDRAMINE 25MG **30** T1C PO Q PM PRN			
FEB 23,2001 FEXOFENADINE HCL 60MG **30** T1C PO Q AM F ALLERGY SYMPTOMS			
FEB 23,2001 ROFECOXIB 25MG TAB **30** T1T PO DY TO CONTROL PAIN			
FEB 12,2001 APAP/CODEINE 300MG/30MG **30** T1T PO Q4H PRN FOR PAIN			
JAN 24,2001 ROFECOXIB 25MG TAB **30** T1T PO DY TO CONTROL PAIN			
JAN 16,2001 APAP/CODEINE 300MG/30MG **30** T1T PO Q4H PRN FPA			

Pharmacy Only
Screened ____ Counseled ____
Checked ____ Returned ____
Rx Received:

KENNETH JONES
DOB: JAN 12,1943
No record of 3rd party eligibility...

58 y/o male
SSN:516 54 9999
#9999

Designated Provider: Unknown
MAR 15,2001@09:22
VCN: 2638.226A

CROW_MEDREC MAR 15,2001@09:22 Provider: SHORR,GREG

	Treatment/Procedures	CPT
	Bx one / mult. or local excision	57500*
	w / wo fulguration (sep proc)	
	Colposcopy (sep proc)	57452*
	Colposcopy cervical bx & / or ECC	57454*
	Cryocautery of cervix	57511*
	Endocervical curettage	57505
	Catherization urethra, simple	53670*
	Endometrial & / or endocervical	58100*
	Bx vaginal mucosa, extensive	57105
	Bx vaginal mucosa, simple	57100*
	Bx vulva / perineum (sep proc) 1 les.	56605*
	Bx vulva / perineum, each add. lesion	56606*
	Dest. vulvar lesion(s), simple	56501
	I & D Bartholin's gland abscess	56420*
	I & D vag. hematoma (post-ob)	57022
	I & D vulva or perineal abscess	56405*
	Pessary / other device insert/fit	57160*
	Pessary, rubber (Medicare)	A4561
	Pessary, non-rubber (Medicare)	A4562

	Supplies	Qty	CPT
	AC Splint		L3670
	Ace Wrap		A4460
	Alc. Swabs		A4245
	Cane		E0100
	Cast Boot		L3260
	Crutches		E0112
	Gauze		A62___
	Knee Brace		L1830
	Nebulizer supplies		E0601
	O2		E0431
	Surg Supp		A4649
	Surg Tray		A4550
	Tape		A4454
	Wrist Brace		L3800

	Injection/Infusion	CPT
	Depo-Provera 150 mg	J1055
	Injection antibiotic, IM	90788
	Injection med. SQ or IM	90782
	Lupron 3.75 mg	J1950
	Lupron 11.25 mg	J9217
	Contraception	**CPT**
	Diaphragm / cervical cap	67170
	Diaphragm / supply	99070
	IUD insertion	58300*
	IUD removal	58301
	IUD supply	99070
	Point of Care Lab	**CPT**
	Finger Stick Glucose	82948
	Hemocult Stool	82270
	Hemoglobin	85018
	Urine Dip w/o Micro	81000

	Immunization	CPT
	Flu	90724
	Hep A Adult	98632
	Hep B Adult	90746
	Pneumovax	90732
	Td Adult	90718
	PPD	86580
	Patient Ed	**Code**
	Self Breast Exam	
	STD	
	Parenting	
	Domestic Violence	
	Contraception	
	CA Prevention	
	DM Diet	
	DM Foot care	
	Drugs/ETOH	
	Exercise	

A / I / R	ICD-9	Active Problems & POVs
	840.4	ROTATOR CUFF TEAR (L)
	305.1	TOBACCO SMOKER
	211.4	TUBULAR ADENOMA REMOVE
	754.71	ANT CAVUS B/L
	735.5	CLAW TOES 2-5 B/L
	389.18	HFSNHL AU
	280.9	IRON DEFICIENCY ANEMIA
	305.11	SMOKER 5-7 CIGARETTES/
	530.81	CHRONIC GERD W/BARRETT
	V61.0	FAMILY CONFLICT
	692.9	ECZEMA
	523.8	GINGIUA HYPERTROPHY 2D
	303.90	CHRONIC ALCOHOLISM-6 R
	--------	----------POVs----------
	V68.1	MED REFILL
	719.40	ARTHRALGIA
	465.9	URI
	380.10	TRAUMATIC OTITIS EXTER
	780.9	LEFT WITHOUT BEING SEE

A / I / R	ICD-9	ICD-9 Pick List
	789.00	Abd pain
	706.1	Acne
	305.00	Alcohol abuse
	291.81	Alcohol withdrawal
	995.3	Allergies
	286.9	Anticoagulation clinic
	300.00	Anxiety
	493.90	Asthma
	724.5	Back pain
	490.	Bronchitis
	414.00	CAD
	496.	COPD
	V68.9	Chart review
	786.50	Chest pain
	780.9	Chronic pain
	V65.49	Counseling
	250.01	DM
	525.9	Dental pain
	V72.2	Dental/oral health visit

A / I / R	ICD-9	ICD-9 Pick List
	311.	Depressive disorder
	536.8	Dyspepsia
	303.90	ETOH abuse
	692.9	Eczema
	796.2	Elevated BP
	525.1	Extraction
	V72.0	Eye exam
	729.5	Foot pain
	707.1	Foot ulcer
	530.81	GERD
	558.9	Gastroenteritis
	401.9	HTN
	784.0	Headache
	272.4	Hyperlipidemia
	244.9	Hypothyroidism
	V07.9	Immune update
	780.52	Insomnia
	719.46	Knee pain
	V72.6	Lab

A / I / R	Additional Purpose of Visit

Notes for problem: Remove Note:

Notes for problem: Remove Note:

Notes for problem: Remove Note:

Plans/Instructions/Appointments/Referrals

RTC: **APPT LENGTH:**

X	Preventative Med	New	Estbl
	Infant (< 1 yr.)	99381	99391
	Early childhood (1-4 yrs.)	99382	99392
	Late childhood (5-11 yrs.)	99383	99393
	Adolescent (12-17 yrs.)	99384	99394
	18-39 yrs	99385	99395
	40-64 yrs	99386	99396
	65 yrs & >	99387	99397

X	E&M Visit Level	New	Estbl
	Indicate level w/ an "X" and CIRCLE whether NEW or ESTABLISHED patient.		
	CC Hist 3, ROS 0, 1 organ sys/ body area	99202	99212
	CC Hist 3, ROS 1, 2-7 o.s./ b.a.	99203	99213
	CC Hist4, ROS 2-9, 2-7 o.s./ b.a.	99204	99214
	CC Hist 4, ROS 10-14, 8-12 o.s./ b.a.	99205	99215
	Nurse Visit:		99211
	Counseling: ___15 min. / ___30 min. / ___45 min.		9940_

Provider's Signature:

KENNETH JONES
DOB: JAN 12,1943
No record of 3rd party eligibility...

58 y/o male
SSN:516 54 9999
#9999

MAR 15,2001@09:22
VCN: 2638.226A

7.0 Appendix B: Mail Merge Fields

Header field	Description	Category	Origin
<<l1>> thru <<l20>>	Lab	Infants, children, adult females, adult males	ORDERABLE
<<l1a>> thru <<l20a>>	Lab code	Infants, children, adult females, adult males	ORDERABLE
<<r1>> thru <<r25>>	Radiology	Infants, children, adult females, adult males	ORDERABLE
<<r1a>> thru <<r25a>>	Radiology code	Infants, children, adult females, adult males	ORDERABLE
<<e1>> thru <<e20>>	Exams	Infants, children, adult females, adult males	ORDERABLE
<<e1a>> thru <<e20a>>	Exam code	Infants, children, adult females, adult males	ORDERABLE
<<i1>> thru <<i10>>	Immunizations	Infants, children, adult females, adult males	ORDERABLE
<<i1a>> thru <<i10a>>	Immunization code	Infants, children, adult females, adult males	ORDERABLE
<<y1>> thru <<y20>>	Pt Education	Infants, children, adult females, adult males	ORDERABLE
<<y1a>> thru <<y20a>>	Pt Education code	Infants, children, adult females, adult males	ORDERABLE
<<t1>> thru <<t20>>	Treatments	Infants, children, adult females, adult males	ORDERABLE
<<t1a>> thru <<t20a>>	Treatments	Infants, children, adult females, adult males	ORDERABLE
<<s1>> thru <<s20>>	Injections	Infants, children, adult females, adult males	ORDERABLE
<<s1a>> thru <<s20a>>	Injection code	Infants, children, adult females, adult males	ORDERABLE
<<z1>> thru <<z15>>	Supplies	Infants, children, adult females, adult males	ORDERABLE
<<z1a>> thru <<z15a>>	Supplies code	Infants, children, adult females, adult males	ORDERABLE
<<d1>> thru <<d60>>	Diagnosis	Infant,Child, Teen Male, Teen Female, Adult Male, Adult Female, Senior Male,Senior Female	ICD PREFERENCE
<<d1c>> thru <<d60c>>	Diagnosis code	Infant,Child, Teen Male, Teen Female, Adult Male, Adult Female, Senior Male,Senior Female	ICD PREFERENCE
<<p1>> thru <<p20>>	Active Problems, recent pov	All patients	RPMS DATA
<<p1c>> thru <<p20c>>	Active Problem, pov code	All patients	RPMS DATA
<<a1>> thru <<a5>>	Allergies	All patients	RPMS DATA
<<h1>>	Pap	Adult females	RPMS DATA
<<h2>>	Glucose	All parients	RPMS DATA
<<h3>>	PPD	All parients	RPMS DATA
<<h4>>	Mammogram	Adult females	RPMS DATA
<<h5>>	Pelvic	Adult females	RPMS DATA
<<h6>>	Breast	Adult females	RPMS DATA
<<h7>>	Pelvic	Adult females	RPMS DATA
<<h8>>	Rectal	Adult males, adult females	RPMS DATA
<<h9>> thru <<h26>>	Immunization reminders. Specific immunization are not assigned to specific header fields – but they will always be in the range h9 to h26	All patients	RPMS DATA
<<md1>> thru <<md15>>	Medication	All patients	RPMS DATA
<<patient>>	Patient Name: First name Last name	All patients	RPMS DATA
<<b29>>	Patient Name Last name, First name	All Patients	RPMS DATA
<<timestamp>>	Date and time form is printed	All patients	
<<chart>>	HRN	All patients	RPMS DATA
<<agesex>>	Age and Sex	All patients	RPMS DATA
<<dob>>	Date of Birth	All patients	RPMS DATA
<<b27>>	Third Party Billing	All patients	RPMS DATA
<<vcn>>	Visit control number	All patients	RPMS DATA
<<tribe>>	Tribe	All patients	RPMS DATA
<<community>>	Community	All patients	RPMS DATA
<<ssn>>	Ssn	All patients	RPMS DATA
<<elig>>	Eligibility (chs/direct)	All patients	RPMS DATA
<<Vbar>>	Bar Code	All patients	RPMS DATA
<<x29>>	Designated provider	All patients	RPMS DATA
<<lc>>	Living Children	ADULT FEMALES	RPMS Data
<<grav>>	Gravida	ADULT FEMALES	RPMS Data
<<para>>	Para	ADULT FEMALES	RPMS Data
<<ab>>	Abortions	ADULT FEMALES	RPMS Data
<<fpm>>	Family Planning Method	ADULT FEMALES	RPMS Data
<<Lab2>>	FP Method (label)	ADULT FEMALES	Label
<<Lab1>>	LMP (label)	ADULT FEMALES	Label
<<x14>>	MALE	ADULT MALES	Label
<<x14>>	FEMALE	ADULT FEMALES	Label
<<x19>>	Eye	ADULT FEMALES	Label
<<x2>>	Vagina	ADULT FEMALES	Label
<<x2>>	Scrotum	ADULT MALES	Label
<<x21>>	EKG	ADULT FEMALES	Label
<<x22>>	Pk Flow	ADULT FEMALES	Label
<<x22>>	HC	INFANTS	Label

Header field	Description	Category	Origin
<<x22>>	Pk Flow	ADULT MALES	Label
<<x23>>	O2 Sat	ADULT FEMALES	Label
<<x23>>	O2 Sat	ADULT MALES	Label
<<x24>>	Glucose	ADULT MALES	Label
<<x24>>	Glucose	ADULT FEMALES	Label
<<x24>>	Glucose	CHILDREN	Label
<<x29>>	DP	ADULT MALES	Label
<<x29>>	DP	ADULT FEMALES	Label
<<x29>>	DP	CHILDREN	Label
<<x29>>	DP	INFANTS	Label
<<x3>>	Urethra	ADULT FEMALES	Label
<<x3>>	Testes	ADULT MALES	Label
<<x30>>	ETOH	ADULT FEMALES	Label
<<x30>>	ETOH	ADULT MALES	Label
<<x30>>	ETOH	CHILDREN	Label
<<x31>>	Tobacco	ADULT FEMALES	Label
<<x32>>	ET Smoke	INFANTS	Label
<<x32>>	ET Smoke	ADULT FEMALES	Label
<<x32>>	ET Smoke	ADULT MALES	Label
<<x32>>	ET Smoke	CHILDREN	Label
<<x33>>	Drugs	ADULT FEMALES	Label
<<x33>>	Drugs	ADULT MALES	Label
<<x33>>	Drugs	CHILDREN	Label
<<x4>>	Cervix	ADULT FEMALES	Label
<<x4>>	Prostate	ADULT MALES	Label
<<x40>>	LMP	ADULT FEMALES	Label
<<x41>>	FP	ADULT FEMALES	Label
<<x5>>	Adnexa	ADULT FEMALES	Label
<<x5>>	Circ/f'skin	ADULT MALES	Label
<<x6>>	Uterus	ADULT FEMALES	Label
<<x7>>	Bladder	ADULT FEMALES	Label
<<x8>>	RectoVag	ADULT FEMALES	Label
<<x10>>	Breast Exam	ADULT FEFMALES	Label
<<x11>>	Contour	ADULT FEFMALES	Label
<<x12>>	D/C	ADULT FEFMALES	Label
<<x13>>	Masses	ADULT FEFMALES	Label

8.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the ITSC Help Desk by:

Phone: (505) 248-4371 or
(888) 830-7280

Fax: (505) 248-4199

Web: http://www.rpms.ihs.gov/TechSupp.asp

Email: RPMSHelp@mail.ihs.gov